2004 HEALTH INSURANCE RENEWAL COMPARISON

2004 Health Insurance Renewal Benefit Comparison

Description of Benefit	2003 Current CHP Plan	2004 Renewal CHP Plan	2004 Proposed CHP Plan	2003 Current Plan	2004 Current HPSE Plan	2004 Renewal HPSE Plan
Plan Type	Plan B	Plan F	Plan M	Optimum	Optimum Type	Plan 1501/ Plan M
Physician Services			"State Model"			"State Model"
Office Visit (during regular hours)	$10.00	$10.00	$15.00	$10.00	$10.00	$15.00
Office Visit (After regular hours)	$15.00	$15.00	$20.00	$10.00	$10.00	$15.00
Specialty Visit w/ PCP Referral	$10.00	$10.00	$25.00	$10.00	$10.00	$25.00
Outpatient Surgical Care	$10.00	$10.00	$25.00	$0.00	$0.00	$15
Mental Health outpatient care (20 Visits)	$20.00	$20.00	$25.00	$20.00	$20.00	$25 (30 visits)
Hospital Services						
Hospital benefits covered	$0.00	$0.00	$250 per admission	$0.00	$0.00	$250 per admission
Outpatient Surgical Procedures	$0.00	$0.00	$0.00	$0.00	$0.00	$100/$50.00 Urgent Care
Mental Health Inpatient Care	$0, (Max 31 Days)	$0, (Max 31 Days)	$250 per admission (31days)	$0 (Max 30 Days)	$0, (Max 30 Days)	$250/adm, (Max 30 Days)
Maternity Services						
Physician Services						
Office Visit w/ PCP	$10.00	$10.00	$15.00	$10.00	$10.00	$15.00
Specialty Visit w/ PCP referral	$10.00	$10.00	$25.00	$10.00	$10.00	one time $25.00
Hospital Services						
All Maternity Inpatient Care	$0.00	$0.00	$250 per admission	$0.00	$0.00	$250 per admission
Emergency Services						
Emergency room visits	$50 per episode	$100 per episode	$100 per episode	$50 waived if admitted	$50 waived if admitted	$100 per episode waived if admitted
Emergency services outside area	$50 per episode	$100 per episode	$100 per episode	$50 waived if admitted	$50 waived if admitted	$100 per episode waived if admitted
Urgent Care Services	$15.00	$15.00	$20.00	$10.00	$10.00	$25.00
Other Benefits						
Home Health Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Home Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Outpatient Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Hospice Inpatient Care	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Skilled nursing facility for up to 60 days per admission	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Durable medical equipment and prosthetic medical appliances	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Alcohol and Drug Abuse	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Detox Only-Combined with Mental Health Benefits	Detox Only-Limit 5 days	Covered by Endorsement ONLY	Covered by Endorsement ONLY
Outpatient prescription drugs	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY	Covered by Endorsement ONLY
Visits for short-term physical/speech or other rehabilitation therapies	$10.00	$10.00	$25.00	$10.00	$10.00	$25.00
Routine eye exams for vision correction	$10.00	$10.00	$15.00	$10.00	$10.00	$15.00
Exclusions						
Maximum amt. Co-pay for 1 calendar yr.	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (*Per Family-Excludes Prescription Drug Copays*)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (Per Family)	$1,500.00 (Per Member) $3,000.00 (Per Family)
Prescription Drug Benefit				mail order:(2) copays for 90 day supply	mail order:(3) copays for 90 day supply	mail order:(3) copays for 90 day supply
Generic Drugs	$7.00	$7.00	$10.00	$7.00	$7.00	$10.00
Preferred Brand Drugs	$20.00	$20.00	$25.00	$14.00	$14.00	$25.00
Non-Preferred Brand Drugs	$35.00	$35.00	$40.00	$30.00	$30.00	$40.00
3-Tier Rates						
Employee	$300.10	$342.00	$326.60	$291.71	$367.96	$328.29
Employee + 1	$621.20	$708.00	$676.00	$603.78	$761.61	$679.48
Family	$795.30	$906.40	$865.40	$772.92	$974.96	$869.93

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