2005 HEALTH INSURANCE RENEWAL COMPARISON

2005 Health Insurance Renewal Benefit Comparison

Description of Benefit	2005 Renewal CHP Plan	2005 Proposed CHP Plan (1)	2005 Proposed CHP Plan (2)	2005 Current Vista Plan	2005 Proposed Vista Plan (1)	2005 Proposed Vista Plan (2)
Plan Type	Plan F	Plan F	Plan P	Plan 1427	Plan 1427	Plan P
Physician Services						
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	$10.00	$10.00	$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	$0.00
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	$100 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	$100 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	$20.00
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	Covered by Endorsement ONLY	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	$15.00	$15.00	$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)	$2,000.00 (Per Member) $4,500.00 (*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)	$2,000.00 (Per Member) $4,500.00 (*Per Family-Excludes Prescription Drug Copays*)
Prescription Drug Benefit				mail order (3) 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	$10.00	$10.00	$7.00	$10.00	$10.00
Preferred Brand Drugs	$20.00	$25.00	$25.00	$14.00	$25.00	$25.00
Non-Preferred Brand Drugs	$35.00	$40.00	$40.00	$30.00	$40.00	$40.00
Guarantees						
Employee	$392.50	$386.40	$374.30	$407.64	$393.28	$385.80
Employee + 1	$812.50	$799.90	$744.80	$843.74	$814.01	$798.54
Family	$1,040.20	$1,024.10	$991.90	$1,080.10	$1,042.04	$1,022.23

Attachment # 3
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