COMPARISON OF PROPOSED HEALTH PLAN TO CURRENT HMP PLAN C

	CURRENT HMP PLAN C	PROPOSED PLAN	
	In-Network	In-Network	Out-of-Network
Overall Lifetime Maximum Benefit	None	Unlimited	Unlimited
Calendar Year Deductible	None	$300 per individual $600 per family	$300 per individual $600 per family
Calendar Year Out-of Pocket Limit	$1,500 per individual $3,000 per family	$1,500 per individual $3,000 per family	$1,500 per individual $3,000 per family
PHYSICIAN FEE			
Office Visit Charge	$15 co-pay, then 100%	$25 co-pay, then 100%	60% after Deductible
Office visit - Other Services/Supplies	100%	90% after Deductible	60% after Deductible
Specialists Office Visits	$15 co-pay, then 100%	$25 co-pay, then 100%	60% after Deductible
Specialist visit - Other Services/Supplies	100%	90% after Deductible	60% after Deductible
Routine Physical	$15 co-pay, then 100%	$25 co-pay, then 100%	60% after Deductible
Well-Baby Care	$15 co-pay, then 100%	$25 co-pay, then 100%	60% after Deductible
Allergy Services (testing, treatment, serum, injections)	$15 co-pay, then 100%	$25 co-pay, then 100%	60% after Deductible
Immunizations/Vaccinations (up to age 16)	$15 co-pay, then 100%	100%, Deductible Waived	60% after Deductible
Immunizations/Vaccinations (age 17and older)	Not covered	100%, Deductible Waived	60% after Deductible
Treatment for Obesity	Not covered	$25 co-pay, then 100%; Deductible Waived (to include intensive nutritional, behavioral or psychological counseling for participants age 18 and over with a BMI >30)	60% after Deductible
Tobacco Use Treatment	Not covered	$25 co-pay, then 100%; Deductible Waived Intensive behavioral or psychological counseling is a covered benefit for participants age 18 and older. Coverage is limited to 2 visits per month for 3 months; more visits may be approved if medically necessary	60% after Deductible
Treatment for Lipid Disorders, Diabetes and Hypertension	$15 co-pay, then 100% Intensive behavioral or psychological counseling is not covered as a benefit for these diagnoses.	$25 co-pay, then 100% Deductible waived. Intensive behavioral or psychological counseling is a covered benefit for participants age 18 and older. Coverage is limited to 2 visits per month for 3 months; more visits may be approved if medically necessary.	60% after Deductible
EMERGENCY/URGENT SERVICES			
Urgent Care Facility	$40 co-pay	$25 co-pay, then 100%; Deductible Waived	60% after Deductible
Emergency Room Services	$40 co-pay + $15 physician fee per occurrence If hospitalized the co-pay will be waived	$50 co-pay, then 100%; Deductible Waived - if hospitalized the co-pay will be waived	$50 co-pay, then 100%; Deductible Waived-if hospitalized the co-pay will be waived
Ambulance Services	Covered in full when medically necessary	90% after Deductible	60% after Deductible
HOSPITAL FACILITY SERVICES			
Inpatient	100%	90% after Deductible	60% after Deductible
Intensive Care Unit	100%	90% after Deductible	60% after Deductible
Misc. Services & Supplies	100%	90% after Deductible	60% after Deductible
MATERNITY SERVICES			
Initial Office Visit	$15 co-pay, then 100%	$25 co-pay, then 100%; Deductible Waived	60% after Deductible
Subsequent Office Visits	$0 co-pay, then 100%	100%; Deductible waived	60% after Deductible
OUTPATIENT SERVICES			

COMPARISON OF PROPOSED HEALTH PLAN TO CURRENT HMP PLAN C

	CURRENT HMP PLAN C	PROPOSED PLAN	
	In-Network	In-Network	Out-of-Network
Outpatient Surgery	100%	$150 co-pay, then 100%; Deductible Waived *(includes facility charges, professional fees, anesthesia, x-ray and lab services)*	60% after Deductible
Diagnostic X-Ray & Lab	$15 co-pay, then 100%	90% after Deductible *(preventative, in-network lab work is covered at 100%)*	60% after Deductible
Outpatient "LabOne" Services	100%	100%, Deductible Waived	N/A
Outpatient Therapy Physical & Occupational	Short-term coverage $15 co-pay; limited to 2 months	90% after Deductible	60% after Deductible
MENTAL HEALTH SERVICES			
Mental Health Services In-Patient (non-serious mental illness)	100% Hospital 20 visits per calendar year	90% after Deductible	60% after Deductible
Mental Health Services Out-Patient	$30 co-pay 20 visits per calendar year	$25 co-pay, then 100%	60% after Deductible
CHEMICAL DEPENDENCY SERVICES			
Inpatient	100%	90% after Deductible	60% after Deductible
Outpatient	$15 co-pay, then 100%	$25 co-pay, then 100%; Deductible Waived	60% after Deductible
Inpatient and Outpatient Combined Lifetime Maximum Benefit	3 separate series of each treatments for each covered person	3 separate series of each treatments for each covered person	3 separate series of each treatments for each covered person
OTHER COVERED SERVICES			
Durable Medical Equipment	100%	90% after Deductible	60% after Deductible
Home Health Care	100%	90% after Deductible	60% after Deductible
Hospice Care	100%	90% after Deductible	60% after Deductible
Skilled Nursing Facility/ Extended Care Facility	100%	90% after Deductible	60% after Deductible
All Other Eligible Expenses	100%	90% after Deductible	60% after Deductible
PRESCRIPTIONS			
Retail Pharmacy (30 day supply)			
Generic	$10 co-pay, then 100%	$10 co-pay, then 100%	$10 co-pay, then 100%
Brand Name Formulary	$15 co-pay, then 100%	$25 co-pay, then 100%	$25 co-pay, then 100%
Brand Name Non-Formulary	$30 co-pay, then 100%	$40 co-pay, then 100%	$40 co-pay, then 100%
Mail Order (90 day supply)			
Generic	$20 co-pay, then 100%	$20 co-pay, then 100%	$20 co-pay, then 100%
Brand Name Formulary	$30 co-pay, then 100%	$50 co-pay, then 100%	$50 co-pay, then 100%
Brand Name Non-Formulary	$60 co-pay, then 100%	$80 co-pay, then 100%	$80 co-pay, then 100%

OUT OF NETWORK COVERAGE	
Out of Network Coverage	None

This summary of benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. Please refer to your Summary Plan Description (SPD) for a complete listing of services, limitations and exclusions. The SPD prevails in the event of discrepancies

Special Value Based Benefits

All prescription medications for the treatment of diabetes (including supplies), hypertension, or high cholesterol will be covered at the generic co-pay of $10 for retail and $20 for mail order.

Prescription weight loss and smoking cessation drugs are covered.

Colorectal Cancer screening is a covered benefit for men and women age 50 and over, and may be initiated at an earlier age with certain risk factors, and if the early screening is determined by a clinician.

Screening Method	Approved Interval for Coverage
Colonoscopy	Every 10 years
Flexible sigmoidoscopy	Every 5 years
Double-contrast barium enema	Every 5 years
Fecal occult blood test (FOBT)	Every year

EMPLOYEE PAY PERIOD HEALTH PLAN PREMIUMS

	HMP C PLAN	PROPOSED PLAN	SAVINGS
EMPLOYEE ONLY	$0	$0	$0
EMPLOYEE AND SPOUSE	$32.32	$30.59	$2
EMPLOYEE AND CHILDREN	$44.45	$29.83	$15
EMPLOYEE AND FAMILY	$75.06	$69.40	$6