

Canisius College
Benefit Comparison

	Independent Health PPO		Flex Fit Active	Independent Health Flex Fit Flex Fit Family	Flex Fit Independent	Independent Health Encompass Essential Plus
Medical Services	In-Network	Out-of-Network				
Office Visits	\$10	Subject to deductible & coinsurance	\$10 (\$20 for dependents under age 19)	\$15 (\$0 for dependents under age 19)	\$20	\$25
Routine Physicals	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Well Child Visits and Immunizations (to age 19)	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic X-Rays	\$10	Subject to deductible & coinsurance	Primary \$10 (\$20 for dependents under age 19) Specialist \$20	Primary \$15 (\$0 for dependents under age 19) Specialist \$20	\$20	\$40
Laboratory Testing	\$10	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Chiropractic Care	\$10	Subject to deductible & coinsurance	\$20	\$20	\$20	\$25
Specialist Visits	\$10	Subject to deductible & coinsurance	\$20	\$20	\$20	\$40
Women's Services						
Maternity Care (Pre/Post-Natal Care)	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full after initial diagnosis Adult: \$25, Child: \$5
Inpatient Maternity	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	\$500 per admission
Gynecological Visits	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Mammograms	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Routine Pap Smears	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	Covered in full
Hospital Care						
Inpatient Stay	Covered in full	Subject to deductible & coinsurance	Covered in full	Covered in full	Covered in full	\$500 per admission
Outpatient Surgery Facility	\$10	Subject to deductible & coinsurance	\$75	\$75	\$75	\$75
Chemotherapy, Radiation Therapy, Inhalation Therapy	\$10	Subject to deductible & coinsurance	\$20	\$20	\$20	\$25
Cardiac Rehabilitation	Covered following a heart transplant, CHF, bypass surgery or a myocardial infarction, for up to 36 visits per event with a \$15 copayment per visit.	Subject to deductible & coinsurance	\$20 (36 visits per yr)	\$20 (36 visits per yr)	\$20 (36 visits per yr)	\$25 (up to 36 visits per event)
Occupational, Speech, Physical Therapy	\$15 (up to 60 aggregate visits per year)	Subject to deductible & coinsurance	\$20 (20 aggregate visits)	\$20 (20 aggregate visits)	\$20 (20 aggregate visits)	\$25 (up to 20 visits per contract year)
Emergency Room Visits	\$100	\$100	\$75	\$75	\$75	\$100 (waived if admitted)
Emergency Ambulance	\$100	\$100	\$75	\$75	\$75	\$50
Mental Health Care						
Inpatient	Covered in full for up to 30 days per calendar year	Subject to deductible & coinsurance	Covered in full (30 days per year)	Covered in full (30 days per year)	Covered in full (30 days per year)	\$500 per admission (semi-private room, per admission; visit limits may apply based on diagnosis)
Outpatient (number of visits may vary by diagnosis)	\$10 (60 visits per member per year)	Subject to deductible & coinsurance	\$20 (20 visits per member per year)	\$20 (20 visits per member per year)	\$20 (20 visits per member per year)	\$40 (visit limits may apply based on diagnosis)
Substance Abuse Treatment						
Inpatient Substance Abuse - Detox	Covered in full (7 days detoxification only)	Subject to deductible & coinsurance	Covered in full (7 days)	Covered in full (7 days)	Covered in full (7 days)	\$500 per admission (7 days)
Inpatient Substance Abuse - Rehab	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient Substance Abuse	\$10 (limited to 60 visits per calendar year)	Subject to deductible & coinsurance	\$20 (limited to 60 visits per calendar yr)	\$20 (limited to 60 visits per calendar yr)	\$20 (limited to 60 visits per calendar yr)	\$25 (60 visits per year)

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Other Services	In-Network	Out-of-Network				
Diabetic Supplies and Equipment	\$15	Subject to deductible & coinsurance	\$10	\$15	\$20	\$25
Durable Medical Equipment	50% coinsurance - unlimited benefit	Subject to deductible & 50% coinsurance	20% coinsurance with an annual allowance of \$1,000	20% coinsurance with an annual allowance of \$1,000	20% coinsurance with an annual allowance of \$1,000	50% copay with a \$1,000 maximum per contract year
Home Health Care	\$10 365 days (combined in-and out-of network)	Subject to deductible & coinsurance	\$20 (unlimited days)	\$20 (unlimited days)	\$20 (unlimited days)	\$25 (unlimited days)
Hospice	Covered in full (unlimited days)	Subject to deductible & coinsurance	Covered in full (unlimited days)	Covered in full (unlimited days)	Covered in full (unlimited days)	Covered in full (unlimited)
Prosthetic Devices	50% copay	Subject to deductible & coinsurance	50% copay	50% copay	50% copay	50% copay (\$5,000 maximum)
Skilled Nursing Facility	Covered in full (45 days)	Subject to deductible & coinsurance	Covered in full (45 days)	Covered in full (45 days)	Covered in full (45 days)	\$500 per admission (30 days)
Prescription Drugs	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)	\$5/\$30/\$45 (through Pharmacy Benefit Dimensions)
Vision Care						
Routine Vision Exam	\$15	Not Covered	\$10 (\$20 for dependents under age 19)	\$20 (\$5 for dependents age 0-14) (\$15 for dependents age 15-18)	\$20	20 (once every 12 months)
Laser Vision Correction	15% discount off standard fees, 5% discount off promotional pricing	Not Covered	50% copay, up to \$400 per eye	50% copay, up to \$400 per eye	50% copay, up to \$400 per eye	15% discount (based on standard pricing)
Dependent Coverage						
Dependent/Student Coverage to Age	25/25		19/19	23/23	26/26	25/25
Lifestyle Benefit						
\$250 Allowance			Debit Card for health club membership	Debit Card for family fitness programs	Debit Card for alternative therapies	
			Out-of-Network Only	Out-of-Network Only	Out-of-Network Only	Out-of-Network Only
Deductible	N/A	\$250 / \$500	\$1,000 / \$2,000	\$500 / \$1,000	\$250 / \$500	\$1,000 / \$2,000
Coinsurance	N/A	80% / 20%	80% / 20%	80% / 20%	80% / 20%	70% / 30%
Out-of-Pocket Maximum	N/A	\$1,000 / \$2,000	\$5,000 / \$10,000	\$2,500 / \$5,000	\$1,000 / \$2,000	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	\$1,000,000

This analysis is for comparison purposes only and is not a contract.