CANISIUS COLLEGE

	Independent Health	Independent Health Plan		
	Traditional Deductible	Flex Fit Active	Flex Fit Family	Flex Fit Independent
EMPLOYEE Annual Premium Rate Tier 1 - hired prior to 7/1/1998 Tier 2 - hired after 7/1/1998	Single $731.28 (Tier 1) Family $2,015.28 (Tier 1)	Single $390.24 (Tier 1 & 2) Family $1,034.16 (Tier 1 & 2)	Single $390.24 (Tier 1 & 2) Family $1,034.16 (Tier 1 & 2)	Single $390.24 (Tier 1 & 2) Family $1,034.16 (Tier 1 & 2)
Medical Services				
Office Visits	Subject to deductible & 20% coinsurance	$10 ($20 for dependents under age 19)	$15 ($0 for dependents under age 19)	$20
Routine Physicals	Covered in full	$10 (19 yrs of age & over) $20 (up to 19 yrs of age)	$15 (19 yrs of age & over) $0 (up to 19 yrs of age)	$5
Well Child Visits & Immunizations (to age 19)	Covered in full	Covered in full	Covered in full	Covered in full
Diagnostic X-Rays	Covered in full	Primary $10 ($20 for dependents under age 19) Specialist $20	Primary $15 ($0 for dependents under age 19) Specialist $20	$20
Laboratory Testing	Covered in full	Covered in full	Covered in full	Covered in full
Chiropractic Care	Subject to deductible & 20% coinsurance	$20	$20	$20
MRI (Pre-authorization required)	Covered in full	$20 No referrals required	$20 No referrals required	$20 No referrals required
Women's Services				
Maternity Care (Pre & Post-Natal Care)	Covered in full	Covered in full	Covered in full	Covered in full
Annual Gyn office visits	Covered in full	$10 (19 yrs of age & over) $20 (up to 19 yrs of age)	$15 (19 yrs of age & over) $0 (up to 19 yrs of age)	$5
Mammograms	Covered in full	Covered in full	Covered in full	Covered in full
Routine Pap Smears	Covered in full	Covered in full	Covered in full	Covered in full
Hospital Care				
Inpatient Stay- semi private room	$250 deductible each confinement	Covered in full	Covered in full	Covered in full
Outpatient Surgery Facility	Covered in full	$75	$75	$75
Chemotherapy, Radiation Therapy, Inhalation Therapy	Administration covered in full	$20	$20	$20
Cardiac Rehabilitation	Subject to deductible & coinsurance (36 visits per event)	$20 (36 visits per yr)	$20 (36 visits per yr)	$20 (36 visits per yr)
Occupational, Speech, Physical Therapy	Subject to the deductible & 20% coinsurance (unlimited visits)	$20 (20 aggregate visits)	$20 (20 aggregate visits)	$20 (20 aggregate visits)
Emergency Room Visits	Covered in full	$40 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Emergency Ambulance	Subject to the deductible & 20% coinsurance	$25	$25	$25
Mental Health Care				
Inpatient	$250 deductible each confinement (limited to 30 days/member/calendar yr)	Covered in full - limited to 30 days per member per calendar yr	Covered in full - limited to 30 days per member per calendar yr	Covered in full - limited to 30 days per member per calendar yr
Outpatient	Subject to deductible & coinsurance. Up to 62 visits/calendar year.	$20 copay (20 visits per member per yr)	$20 copay (20 visits per member per yr)	$20 copay (20 visits per member per yr)
Substance Abuse Treatment				
Inpatient	$250 deductible each confinement (7 days detox, 30 days rehab)	Detox covered in full. Inpatient Rehab not covered	Detox covered in full. Inpatient Rehab not covered	Detox covered in full. Inpatient Rehab not covered
Outpatient	Covered in full (60 visits per member/calendar yr)	$20 (limited to 60 visits/calendar yr)	$20 (limited to 60 visits/calendar yr)	$20 (limited to 60 visits/calendar yr)

CANISIUS COLLEGE

	Independent Health	Independent Health Plan		
	Traditional Deductible	Flex Fit Active	Flex Fit Family	Flex Fit Independent
Other Services				
Diabetic Supplies and Equipment	Subject to the deductible & 20% coinsurance	$10	$15	$20
Durable Medical Equipment	Subject to the deductible & 20% coinsurance	50% coinsurance with an annual allowance of $1,000	50% coinsurance with an annual allowance of $1,000	50% coinsurance with an annual allowance of $1,000
Home Health Care	Covered in full (limited to 365 visits per calendar yr)	$20	$20	$20
Hospice	$250 deductible	Covered in full (210 days)	Covered in full (210 days)	Covered in full (210 days)
Prosthetic Devices	Subject to the deductible & 20% coinsurance	50% copay	50% copay	50% copay
Skilled Nursing Facility	$250 copay	Covered in full (45 days/calendar yr)	Covered in full (45 days/calendar yr)	Covered in full (45 days/calendar yr)
Prescription Drugs	$5/$25/$40	$5/$25/$40	$5/$25/$40	$5/$25/$40
Vision Care				
Routine Vision Exam	$15 copay	$10 copay	$5 copay	$20
Laser Vision Correction	50% copay, up to $400/eye	50% copay, up to $400 per eye	50% copay, up to $400 per eye	50% copay, up to $400 per eye
Lifestyle Benefit				
$250 Allowance	N/A	Debit Card for health club membership	Debit Card for family fitness programs	Debit Card for alternative therapies
Dependent Coverage				
Dependent/Student Coverage to Age	23/23	19/19	23/23	26/26
		Out-of-Network Only	**Out-of-Network Only**	**Out-of-Network Only**
Deductible	$250 / $500	$1000 / $2000	$500 / $1000	$250 / $500
Coinsurance	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Pocket Maximum	$500 / $1000	$5000 / $10,000	$2500 / $5000	$1000 / $2000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

Process	Provider sends claim to carrier.
Method of Payment	Carrier pays provider and sends Explanation of Benefits to member.
Frequently Utilized Centers of Excellence by WNY Participants	Roswell Park Cancer Institute, Kaleida Health (Buffalo), Children's Hospital of Pittsburg, University of Wisconsin, Cleveland Clinic Foundation

This analysis is for comparison purposes only. Please refer to carrier rates and benefit highlights.