HEALTH COVERAGE BENEFIT SUMMARIES

	OPTION I	OPTION II	
	INDEPENDENT HEALTH *ENCOMPASS "D"*	**UNIVERA HEALTHCARE** *SOLUTIONS*	
		Healthy Choices	***Family First***
Lifestyle Benefits			
	N/A	Up to $300 annual allowance toward health club membership, LASIK eye surgery, or teeth whitening	Up to $300 annual allowance toward massage therapy visits and "Swim and Gym" programs
Outpatient Services			
Office visit	Primary: $25 Specialty: $40	Primary: $15 Specialty: $15	Primary: $20 Specialty: $20
Adult immunizations	Primary: $25 Specialty: $40	$15	$20
Well-child visits/immununizations	$0	$15	$0
Allergy testing/treatment	Primary: $25 Specialty: $40	$15 (Allergy serum paid in full)	$20 ($0 for children 0-19) (Allergy serum paid in full)
Chemotherapy	$40	$15	$20 ($0 for children 0-19)
EKG and other diagnostic procedures	Primary: $25 Specialty: $40	Covered in full	Covered in full
Daignostic X-rays	$20	$15	$20 ($0 for children 0-19)
Mammogram	$0	$0	$0
Laboratory testing, including Pap smears	Covered in full	Covered in full	Covered in full
Rehabilitation therapies (physical, occupational and speech)	$20	$15	$20 ($0 for children 0-19)
Out-patient sugical procedures	$75	$75	$75
Medical eye exam	$40	$15	$20 ($0 for children 0-19)
Chiropractic services	$40 (for manual or mechanical manipulation to treat subluxation)	$15 (for medically necessary treatment of the spinal column)	$20 ($0 for children 0-19) (for medically necessary treatment of the spinal column)
Maternity Services			
Physician services	Prenatal / delivery / postpartum Covered in full	Prenatal / delivery / postpartum Covered in full	Prenatal / delivery / postpartum Covered in full
Inpatient hospital services	$250	$250	Covered in full
Maternity admissions	Copayments are not applied to newborn(s)	N/A	N/A
Hospital Services			
Inpatient hospital	$250	$250	$250
Inpatient admissions	Copayments apply to each admission	Copayment limited to 1 copay per member/yr; 2 copays per family/yr	Copayment limited to 1 copay per member/yr; 2 copays per family/yr
Hospice	$250	$250	$250
Emergency Services			
Medically necessary ambulance transportation	$50	$50	$50
Emergency Room	$50	$50	$50
After Hours Care Center	$35	$15	$20
Outpatient Mental Health Services			
Mental health (for short-term, medically necessary crisis intervention)	50% co-insurance for up to 20 outpatient visits per member per calendar year	50% co-insurance for up to 20 out-patient visits per member per year	50% co-insurance for up to 20 out-patient visits per member per year
Substance Abuse Treatment (visit limits apply)			
Detoxification	$250	$250 (7 days per year)	$250 (7 days per year)
Inpatient rehabilitation	Covered with inpatient copay	$250	$250
Outpatient treatment	$40	$15	$20
Additional Services			
Durable medical equipment	50% co-insurance with an annual allowance of $1,000	50% co-insurance	50% co-insurance
Prosthetics & appliances	50% co-insurance	Internal: Covered in full External breast: $15	Internal: Covered in full External breast: $20 ($0 for children)
Skilled nursing facility	$250 (See contract / riders for limitations)	$250 Limited to 45 days per year	$250 Limited to 45 days per year

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Home care services	$40	$15 (limitations apply)	$20 (limitations apply)
Diabetic Services			
Durable medical equipment (for diabetes)	Primary care copayment applies	$15	$20 ($0 for children 0-19)
Insulin and other oral agents	Primary care copayment (base contract), or your prescription copayment applies, whichever is less.	$15	$20 ($0 for children 0-19)
Up to a 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc)	Primary copayment applies	$15	$20 ($0 for children 0-19)
Vision Plan			
Vision coverage	Preferred Vision Plan		
Annual refractive eye examination	$20	$15	$20 ($0 for children 0-19)
Standard plastic lenses	Single vision: $35 Bifocal: $55 Trifocal: $90 Lenticular: $90 Progressive: $100	$60 allowance	$60 allowance
Lens options	UV coating: $12 Tint: $12 Standard anti-reflective: $45 Standard polycarbonate: $35 Standard scratch resistance: $12 Other services: 20% discount		
Frames	Member pays 50% of retail price, up to $130 and 80% of the balance (if any).		
Contact Lenses	Conventional contact lenses: 15% discount (applies to materials only). Fitting and follow-up are not a covered benefit.		
Laser vision correction	U.S. Laser Network for LASIK or PRK: 15% discount on standard fees or 5% off promotional pricing	Up to $300 (see *Lifestyle Benefits*)	Not covered
Frequency limitations	Examinations: once every 12 months Contact lenses: unlimited Frames: unlimited Lenses: unlimited	Examinations: 1 visit per member/yr Lenses, frames, etc - every other yr; annually for children up to 18	Examinations: 1 visit per member/yr Lenses, frames, etc - every other yr; annually for children up to 18
Dental Plan			
Dental coverage	Not covered	Not covered	Not covered
Prescription Plan			
Prescription drug coverage	$10 / $20 / $35	$10 / $25 / $40	$10 / $25 / $40
Contraceptive drugs and devices	Tier 1 oral contraceptives @ $0 copay	Oral contraceptives covered in full	Oral contraceptives covered in full
Additional Benefits & Limitations			
Out-of-network benefits	Deducitble: $500 / $1,000 Co-insurance: 25% Out-of pocket maximum: $2,000 / $4,000	Deductible: $300 / $600 Co-insurance: 25% Out-of pocket maximum: $3,500 / $7,000	
Dependent Eligibility	age 25	age 19	age 19, or age 26 if full-time student
Individual Coverage Monthly Deduction	**$4.44**	**$0.00**	
Family Coverage Monthly Deduction	**$156.46**	**$131.48**	