	FlexFit Select Active	*FlexFit Select Family*	*FlexFit Select Independent*
Adult Immunizations	Primary (age 19+) $15; Specialist (age 19 +) $40	Primary (age 19 +)$ 25; Specialist (age 19 +) $40	Primary $25; Specialist $40
After Hours Care Center	$35	$35	$35
Allergy testing and treatment	$40	$40	$40
Annual Maximum Benefit	N/A	N/A	N/A
Annual Refractive Eye Exam	$10	$5	$20
Chemotherapy, Radiation Therapy, Inhalation Therapy	$40	$40	$40
Chiropractic Care	$25	$25	$25
Contact Lenses	Conventional contact lenses: 15% discount	Conventional contact lenses: 15% discount	Conventional contact lenses: 15% discount
Dental Coverage	Not covered	Not covered	Not covered
Dependent Coverage	Dependents include the spouse or same sex partner, and unmarried dependent children up to age 19, including grandchildren, foster children, and children over which you have legal guardianship	Dependents include the spouse or same sex partner, and unmarried dependent children up to age 23, including grandchildren, foster children, and children over which you have legal guardianship	Dependents include the spouse or same sex partner, and unmarried dependent children up to age 26, including grandchildren, foster children, and children over which you have legal guardianship
Diabetic Insulin and Other Oral Agents	$15 or your prescription copayment, whichever is less - Up to 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.) - $15	$25 or your prescription copayment, whichever is less - Up to 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.) - $25	$25 or your prescription copayment, whichever is less - Up to 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.) - $25
Diagnostic X-rays	$40	$40	$40
Durable Medical Equipment	Covered at 50% coinsurance, with an annual allowance of $1,000	Covered at 50% coinsurance, with an annual allowance of $1,000	Covered at 50% coinsurance, with an annual allowance of $1,000
Durable Medical Equipment (for treating Diabetes)	$15	$25	$25
EKG's and other	Primary (age 0-18) $25; Primary (age 19 +) $15;	Primary (age 0-18) $0; Primary (age 19 +) $25;	Primary $25; Specialist $40

Diagnostic Procedures	Specialist (all ages) $40	Specialist (all ages) $40	
Emergency Ambulance (medically necessary)	$50	$50	$50
Emergency Room Visit	$50	$75	$75
Exclusive Benefits	Use your Active debit card - save up to $250 toward a participating health club membership.	Use your Family debit card - save up to $250 toward a participating family fitness center membership or other sports/after school programs.	Use your Independent debit card - save up to $250 on fees associated with alternative therapies.
Eyeglass Lenses	UV coating: $12; Tint: $12; Standard Anti-Reflective: $45; Standard Polycarbonate: $35; Standard Scratch Resistance: $12; Other Services: 20% discount	UV coating: $12; Tint: $12; Standard Anti-Reflective: $45; Standard Polycarbonate: $35; Standard Scratch Resistance: $12; Other Services: 20% discount	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	Member pays 50% of retail price up to $130, and 80% of the balance, if any	Member pays 50% of retail price up to $130, and 80% of the balance, if any
Frequency Limitations	Exams: once every 12 months; contacts: unlimited; frames: unlimited; lenses: unlimited	Exams: once every 12 months; contacts: unlimited; frames: unlimited; lenses: unlimited	Exams: once every 12 months; contacts: unlimited; frames: unlimited; lenses: unlimited
Home health care	$40	$40	$40
Hospice	$500	$500	$500
Inpatient Hospital	$500	$0 (age 0-18); $500 (age 19+)	$500
Laboratory Testing	$0	$0	$0
Laser Vision Correction	Lasik: 50% copayment, up to $300 ($150 per eye)	Lasik: 50% copayment, up to $300 ($150 per eye)	Lasik: 50% copayment, up to $300 ($150 per eye)
Mammograms	$0	$0	$0
Maternity Inpatient Hospital Services	$500	$0	$500
Maternity Physician Services	Prenatal/delivery/postpartum covered in full	Prenatal/delivery/postpartum covered in full	Prenatal/delivery/postpartum covered in full
Medical Eye Exam	$40	$40	$40
Medicare Creditability	This plan meets the standard level of drug coverage determined by Medicare, therefore this plan provides you with Creditable Coverage	This plan meets the standard level of drug coverage determined by Medicare, therefore this plan provides you with Creditable Coverage	This plan meets the standard level of drug coverage determined by Medicare, therefore this plan provides you with Creditable Coverage

Mental Health Outpatient	50% copayment for up to 20 outpatient visits per member per calendar year	50% copayment for up to 20 outpatient visits per member per calendar year	50% copayment for up to 20 outpatient visits per member per calendar year
Occupational, speech, physical therapy	$25	$25	$25
Office Visits	Primary (age 0-18) $25; Primary (age 19 +) $15; Specialist (age 19 +) $40	Primary (age 0-18) $0; Primary (age 19 +) $25; Specialist (age 19 +) $40	Primary $25; Specialist $40
Out-of-network Coinsurance	30% (50% for DME)	30% (50% for DME)	30% (50% for DME)
Out-of-network Deductible	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000
Out-of-network Out-of-Pocket Maximum	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Outpatient Surgery Facility	$75	$75	$75
Prescription Drugs	$10/$50/$100 (Tier 1 oral contraceptives @ $0 copay)	$10/$50/$100 (Tier 1 oral contraceptives @ $0 copay)	$10/$50/$100 (Tier 1 oral contraceptives @ $0 copay)
Prosthetic Devices	50% copayment	50% copayment	50% copayment
Provider Directory	www.independenthealth.com	www.independenthealth.com	www.independenthealth.com
Skilled Nursing Facility	Inpatient benefit applies (See contract rider for limitation)	Inpatient benefit applies (See contract rider for limitation)	Inpatient benefit applies (See contract rider for limitation)
Standard Plastic Lenses	Single vision: $35; Bifocal: $55; Trifocal: $90; Lenticular: $90; Progressive: $100	Single vision: $35; Bifocal: $55; Trifocal: $90; Lenticular: $90; Progressive: $100	Single vision: $35; Bifocal: $55; Trifocal: $90; Lenticular: $90; Progressive: $100
Substance Abuse Inpatient Detoxification	$500	$0 (age 0-18); $500 (age 19+)	$500
Substance Abuse Inpatient Rehabilitation	Not covered	Not covered	Not covered
Substance Abuse Outpatient	$40 (up to 60 visits per year)	$40 (up to 60 visits per year)	$40 (up to 60 visits per year)
Vision Coverage	Preferred Vision Plan	Preferred Vision Plan	Preferred Vision Plan
Well Child Visits and immunizations	$0	$0	$0