

	<i>FlexFit Select Active</i>	<i>FlexFit Select Family</i>	<i>FlexFit Select Independent</i>	<i>Encompass Essentials</i>
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	Primary \$25; Specialist \$40
Adult Immunizations	Primary (age 19 +) \$15; Specialist (age 19 +) \$40	Primary (age 19 +) \$25; Specialist (age 19 +) \$40	Primary \$25; Specialist \$40	Primary \$25; Specialist \$40
Well Child Visits and immunizations	\$0	\$0	\$0	\$0
Prescription Drugs	\$10/\$30/\$50 (Tier 1 oral contraceptives @ \$0 copay)	\$10/\$30/\$50 (Tier 1 oral contraceptives @ \$0 copay)	\$10/\$30/\$50 (Tier 1 oral contraceptives @ \$0 copay)	\$10/\$50/\$100 (Tier 1 oral contraceptives @ \$0 copay)
Laboratory Testing	\$0	\$0	\$0	\$0
Mammograms	\$0	\$0	\$0	\$25
Diagnostic X-rays	\$40	\$40	\$40	\$25
EKG's and other Diagnostic Procedures	Primary (age 0-18) \$25; Primary (age 19 +) \$15; Specialist (all ages) \$40	Primary (age 0-18) \$0; Primary (age 19 +) \$25; Specialist (all ages) \$40	Primary \$25; Specialist \$40	Primary \$25; Specialist \$40 Ages 0-18 \$5
Provider Directory	www.independenthealth.com	www.independenthealth.com	www.independenthealth.com	www.independenthealth.com
After Hours Care Center	\$35	\$35	\$35	\$40
Emergency Room Visit	\$50	\$75	\$75	\$100
Emergency Ambulance (medically necessary)	\$50	\$50	\$50	\$50
Outpatient Surgery Facility	\$75	\$75	\$75	\$75
Inpatient Hospital	\$500	\$0 (age 0-18); \$500 (age 19+)	\$500	\$500
Maternity Inpatient Hospital Services	\$500	\$0	\$500	\$500 (Separate copay for mother & child - \$1000 total)
Maternity Physician Services	Prenatal/delivery/postpartum covered in full	Prenatal/delivery/postpartum covered in full	Prenatal/delivery/postpartum covered in full	Prenatal/delivery/postpartum covered in full
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)	\$500

Home health care	\$40	\$40	\$40	\$25 (40 visits per year)
Hospice	\$500	\$500	\$500	\$500 per admission
Allergy testing and treatment	\$40	\$40	\$40	\$25/\$40 Ages 0-18 \$5.00
Chiropractic Care	\$25	\$25	\$25	\$25 (\$0 for under 18)
Occupational, speech, physical therapy	\$25	\$25	\$25	\$25 (a combined total of up to 20 visits per calendar year)
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	Covered at 50% coinsurance, with an annual allowance of \$1,000
Durable Medical Equipment (for treating Diabetes)	\$15	\$25	\$25	\$25
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	\$25 or your prescription copayment, whichever is less - Up to 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.) - \$25
Chemotherapy, Radiation Therapy, Inhalation Therapy	\$40	\$40	\$40	\$25 (\$5 for under 18)
Prosthetic Devices	50% copayment	50% copayment	50% copayment	50% with an annual allowance of \$5,000
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	50% copayment for up to 20 outpatient visits per member per calendar year
Substance Abuse Outpatient	\$40 (up to 60 visits per year)	\$40 (up to 60 visits per year)	\$40 (up to 60 visits per year)	\$25 (up to 60 visits per year) \$5 (Ages 0-18)
Substance Abuse Inpatient Detoxification	\$500	\$0 (age 0-18); \$500 (age 19+)	\$500	\$500
Substance Abuse Inpatient Rehabilitation	Not covered	Not covered	Not covered	Not covered

Vision Coverage	Preferred Vision Plan	Preferred Vision Plan	Preferred Vision Plan	Preferred Vision Plan
Annual Refractive Eye Exam	\$10	\$5	\$20	\$10
Medical Eye Exam	\$40	\$40	\$40	\$40 (Ages 0-18 - \$5)
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	Exams: once every 12 months; contacts: unlimited; frames: unlimited; lenses: unlimited
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	UV coating: \$12; Tint: \$12; Standard Anti-Reflective: \$45; Standard Polycarbonate: \$35; Standard Scratch Resistance: \$12; Other Services: 20% discount
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	Single vision: \$35; Bifocal: \$55; Trifocal: \$90; Lenticular: \$90; Progressive: \$100
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	Member pays 50% of retail price up to \$130, and 80% of the balance, if any
Contact Lenses	Conventional contact lenses: 15% discount	Conventional contact lenses: 15% discount	Conventional contact lenses: 15% discount	Conventional contact lenses: 15% discount
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)	Lasik: 15% discount on standard fee or 5% off promotional pricing
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	Dependents include the spouse or saeme sex partner, and unmarried dependent children up to age 25 with full time student status, including grandchildren, foster children, and children over which you have legal guardianship
Annual College Contribution to HRA (Health Reimbursement Arrangement)	\$ 200 – Single \$ 400 – Family	\$ 200 – Single \$ 400 – Family	\$ 200 – Single \$ 400 – Family	\$ 300 – Single \$ 600 – Family

Dental Coverage	Not covered	Not covered	Not covered	Not covered
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.	N/A
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	This plan meets the standard level of drug coverage determined by Medicare, therefore this plan provides you with Creditable Coverage
Annual Maximum Benefit	N/A	N/A	N/A	N/A
Out-of-network Coinsurance	30% (50% for DME)	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	\$1,000/\$2,000
Out-of-network Out-of-Pocket Maximum	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	None