HEALTH BENEFIT COVERAGE SUMMARIES

	INDEPENDENT HEALTH *"FLEXFIT SELECT"*		
	ACTIVE	**INDEPENDENT**	**FAMILY**
Preventive Services			
Physical Exam Basic metabolism test Immunizations Cholesterol test Pap smear HPV screening Mammogram Prenatal and 1 post-partum visit Rh screen Colonoscopy & sigmoidoscopy Prostate test (PSA) Hemoglobin & hemocrit testing HIV screening Chlamydia screening Fecal blood testing Bone mineral density tests Lead screen (childhood or pregnancy) Rubella screening Abdominal aortic aneurysm screen Well child visit	Covered in full (in network) (Out-of-network: covered at 70%; subject to the deductible)	Covered in full (in network) (Out-of-network: covered at 70%; subject to the deductible)	Covered in full (in network) (Out-of-network: covered at 70%; subject to the deductible)
Physician and Other Services			
Office visit	Adult: Primary: $15 Adult: Specialist: $40 Child: Primary: $25 Child: Specialist: $40	Primary: $25 Specialist: $40	Adult: Primary: $25 Adult: Specialist: $40 Child: Primary: $0 Child: Specialist: $40
Allergy testing & treatment	$40	$40	$40
Outpatient surgical procedures (Dr office)	Adult: Primary: $15 Adult: Specialist: $40 Child: Primary: $25 Child: Specialist: $40	Primary: $25 Specialist: $40	Adult: Primary: $25 Adult: Specialist: $40 Child: Primary: $0 Child: Specialist: $40
Emergency and Urgent Care Services			
Emergency room	$100, waived if admitted	$100, waived if admitted	$100, waived if admitted
Ambulance	$100	$100	$100
Participating after-hours care centers	$45	$45	$45
Hospital Services			
Inpatient hospital	$250	$250	Adult: $250 Child: $0
Inpatient hospice	$0	$0	$0
Outpatient surgical procedures (facility)	$75	$75	$75
Skilled nursing facility	$250	$250	Adult: $250 Child: $0
Diagnostic Testing Services			
Laboratory testing	$0	$0	$0
EKG	Adult: Primary: $15 Adult: Specialist: $40 Child: Primary: $25 Child: Specialist: $40	Primary: $25 Specialist: $40	Adult: Primary: $25 Adult: Specialist: $40 Child: Primary: $0 Child: Specialist: $40
Radiology	$40	$40	$40
Maternity Services			
Physician services (pre- & post-natal care)	Adult: Primary: $15 Adult: Specialist: $40 Child: Primary: $25 Child: Specialist: $40	Primary: $25 Specialist: $40	Adult: Primary: $25 Adult Specialist: $40 Child: Primary: $0 Child: Specialist: $40
Inpatient maternity	$250	$250	$0
Mental Health & Substance Abuse			
Inpatient mental health	$250	$250	Adult: $250 Child: $0
Outpatient mental health	$40	$40	$40
Inpatient substance abuse - rehab	$500 (30 days)	$500 (30 days)	Adult: $500 (30 days) Child: $0 (30 days)
Inpatient substance abuse - detox	$250 (7 days)	$250 (7 days)	Adult: $250 (7 days) Child: $0 (7 days)
Outpatient substance abuse	$40 (60 visits)	$40 (60 visits)	$40 (60 visits)

HEALTH BENEFIT COVERAGE SUMMARIES

	INDEPENDENT HEALTH *"FLEXFIT SELECT"*		
	ACTIVE	**INDEPENDENT**	**FAMILY**
Diabetic Supplies & Services			
Diabetic equipment (glucose monitor, etc)	$15	$25	$25
Insulin and other oral agents	$15	$25	$25
Diabetic medical supplies (test strips, etc)	$15	$25	$25
Rehabilitation Services			
Chiropractic services	$25	$25	$25
Physical-Occupational-Speech therapies	$25 (20 visits)	$25 (20 visits)	25 (20 visits)
Cardiac rehabilitation	$25	$25	$25
Pulmonary rehabilitation	$25 (24 visits)	$25 (24 visits)	$25 (24 visits)
Additional Services			
Durable medical equipment	50% copay, up to $1000 per year	50% copay, up to $1000 per year	50% co-pay up tp $1000
Prosthetics & appliances	50% copay	50% copay	50% copay
Chemotherapy	$40	$40	$40
Home health care	$40 (40 visits)	$40 (40 visits)	$40 (40 visits)
Liefstyle benefits	$250 allowance per subscriber per year for membership to a participating fitness club including traditional gyms, health clubs and fitness centers for men and women	$250 allowance per subscriber per year to be used towards complimentary alternative therapies such as acupuncture, massage therapy, dietary counseling, yoga, pilates, tai chi, vitamins and herbs	$250 allowance per subscriber per year for activities provided at family-oriented fitness centers, sports and fitness programs (soccer, swimming, gymnastics, etc), including baby-sitting clinics and day camp
Prescription Drug Coverage			
Prespcription Plan	$10/$20/$35	$10/$20/$35	$10/$20/$35
Contraceptive drugs & devices	$0 copay for Tier 1 OC	$0 copay for Tier 1 OC	$0 copay for Tier 1 OC
Mail order	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply
Creditable coverage (Medicare)	Creditable	Creditable	Creditable
Vision Services			
Medical exam	$40	$40	$40
Routine/Refractive exam	$0	$0	$0
Standard plastic lenses	Single: $10 Bifocal: $10	Single: $10 Bifocal: $10	Single: $10 Bifocal: $10
Frames	$60 allowance	$60 allowance	$60 allowance
Conventional contact lenses	$90 allowance	$90 allowance	$90 allowance
Laser vision correction	15% discount	15% discount	15% discount
Hearing Services			
Hearing exam	$20	$20	$20
Hearing aids	Not covered	Not covered	Not covered
Dental Services			
Preventive & routine	Not covered	Not covered	Not covered
Accidental dental	Based on site of service	Based on site of service	Based on site of service
Dependent Coverage			
Dependent eligibility	19	26	23
Out-of-Network Coverage			
Deductible (out-of network)	$1000/$2000	$1000/$2000	$1000/$2000
Cosinsurance (out-of network)	30%	30%	30%
Out-of-pocket maximum (out-of-network)	$5000/$10000	$5000/$10000	$5000/$10000
Annual maximum (out-of-network)	Unlimited	Unlimited	Unlimited
Lifetime maximum (out-of-network)	Unlimited	Unlimited	Unlimited
Bi-weekly payroll deduction			
Employee Only	$17.60	$17.60	N/A
Employee & Spouse	$74.34	$74.34	N/A
Employee & Child(ren)	$44.34	$44.34	$44.34
Family (employee, spouse and child(ren))	$103.84	$103.84	$103.84