

# IAC Personal Health Plans - Deluxe Plan

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance Options	<input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> 50%	50%
Individual Calendar-Year Out-of-Pocket Maximum <sup>1</sup>	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Physician Charge at Office Visit <i>Other covered services performed are subject to deductible and coinsurance.</i>	\$40 Copay <b>or</b> Deductible and Coinsurance	Deductible and Coinsurance
Routine Mammography <sup>2</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	\$100 Copay, then Deductible and Coinsurance	\$100 Copay, then Deductible and 50% Coinsurance
Ambulance	Deductible and 80% Coinsurance	
<b>OUTPATIENT</b> Diagnostic Lab, X-ray and Tests	Deductible and Coinsurance	Deductible and 50% Coinsurance
Diagnostic Imaging including MRI, CT, and Nuclear Imaging	Deductible and Coinsurance	Deductible and 50% Coinsurance
Surgery	Deductible and Coinsurance	Deductible and 50% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>3</sup>	Deductible and Coinsurance	Deductible and 50% Coinsurance
Mental, Nervous and Chemical Dependency Care <sup>3</sup>	Deductible and 50% Coinsurance	Deductible and 50% Coinsurance
<b>INPATIENT</b> Surgical Services and Confinement	Deductible and Coinsurance	Deductible and 50% Coinsurance
Mental and Nervous Care <sup>3</sup>	Deductible and Coinsurance	Deductible and 50% Coinsurance

### Additional Premium-Saving Options—Save Up to 10%

Outpatient Services <sup>3</sup>	\$20,000 per insured calendar-year maximum
Calendar-Year Maximum <sup>3</sup>	\$100,000 per insured In- and Out-of-Network
Outpatient Surgery <sup>3</sup>	\$250 Copay per occurrence then Deductible and Coinsurance
Inpatient Confinement <sup>3</sup>	\$500 Copay per occurrence then Deductible and Coinsurance

1. Does not include medical and Rx deductibles, copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders and any other expenses not covered. In- and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

2. Deductible, coinsurance and copay waived.

3. See back for additional details and benefit limitations.

**Note: Plan overview complements the IAC Personal Health Plans brochure. See Certificate of Coverage for details.**

## Outpatient Prescription Drug Options

### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

### Option 2

Not applicable

### Option 3

### Copay

Generic \$30

Formulary, non-formulary and specialty drugs available with discount card.

*Discount Card is not an insurance benefit.*

### Option 4

### Copay

Generic \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

### Option 5

### Copay

Generic \$30  
Formulary \$50\*  
Non-Formulary \$75\*  
Specialty Drugs \$100\*

\*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

### Option 6

### Copay

Generic \$30  
Formulary \$50\*\*  
Non-Formulary \$75\*\*  
Specialty Drugs \$100\*\*

\*\*\$1000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Administered by:



Medical insurance underwritten by:



## Exclusions

### CONSULT THE CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF THE CHARGES, SERVICES AND SUPPLIES EXCLUDED FROM COVERAGE.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

Any service or supply in connection with the implant of an artificial organ

Any treatment, service, supply or prescription medication which:

- is not due to a sickness or injury;
- is not recommended by a physician or
- is not medically necessary

Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider

Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day

Any injury or sickness which arises out of or in the course of any employment for wage or profit

An injury or sickness incurred while on active duty with the military of any country or international organization; or resulting from war or any act of war or the participation in a riot or insurrection

Treatment, services or supplies for any loss sustained, incurred due to or contracted as a consequence of a covered person:

- being intoxicated;
- being under the influence of any narcotic, barbituate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage or
- being under the influence of any illegal drug as defined by state or federal law

Treatment, services or supplies related to the teeth, gums and any other associated structures

Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction

Treatment, services or supplies for:

- breast augmentation;
- the removal of breast implants and
- breast reduction surgery unless medically necessary due to a sickness

Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses

Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion

A newborn's well-baby charges including hospital expenses and nursery charges

Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane

Treatment, services or supplies for inpatient chemical dependency disorders

Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco

Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails

Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies

Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery

Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person

Private duty nursing or custodial care

Inpatient personal convenience items

Telephone and e-mail consultations or missed appointment fees

Treatment, services or supplies received or purchased outside the United States, unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services and supplies used in connection with the urgent care are approved for use in the United States

Treatment, services or supplies for complications of conditions that are not covered under the policy

Non-emergency care ambulance services, durable medical equipment that exceeds \$1,000 and certain prescription medications, unless pre-determined

Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy

Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

## Additional Premium-Saving Options

If you want to save on your monthly premiums, consider selecting all or any combination of the following options:

- **\$20,000 Outpatient Services Calendar-Year Maximum:** Outpatient treatment will be limited to a \$20,000 calendar year maximum per covered person.
- **\$250 Outpatient Surgical Services Copay:** All covered charges incurred for surgical services, including surgery, assistant surgery and anesthesiology services received in an outpatient hospital or ambulatory surgical center will be subject to the \$250 copay per occurrence. Covered charges in excess of the copay are paid at your selected calendar-year deductible and coinsurance.
- **\$500 Inpatient Confinement Copay:** All covered charges incurred for each inpatient confinement will be subject to a \$500 copay per occurrence. Covered charges in excess of the copay are paid at your selected calendar-year deductible and coinsurance.
- **\$100,000 Calendar-Year Maximum:** All covered charges will be limited to a \$100,000 calendar-year maximum benefit per covered person. The \$1 million calendar-year maximum benefit will not be applicable.

# IAC Personal Health Plans - Advantage Plan

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	80%	50%
Individual Calendar-Year Out-of-Pocket Maximum <sup>1</sup>	Medical Services & Supplies: \$3,000 Inpatient Confinement & Surgery: \$6,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Physician Charge at Office Visit <i>Other covered services performed are subject to deductible and coinsurance.</i>	\$40 Copay <b>or</b> Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Routine Mammography <sup>2</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	\$100 Copay, then Deductible and 80% Coinsurance	\$100 Copay, then Deductible and 50% Coinsurance
Ambulance	Deductible and 80% Coinsurance	
<b>OUTPATIENT</b>		
Diagnostic Lab, X-ray and Tests	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Diagnostic Imaging including MRI, CT, and Nuclear Imaging	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Surgery	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>3</sup>	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental, Nervous and Chemical Dependency Care <sup>3</sup>	Deductible and 50% Coinsurance	Deductible and 50% Coinsurance
<b>INPATIENT</b>		
Surgical Services and Confinement	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental and Nervous Care <sup>3</sup>	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance

- Does not include medical and Rx deductibles, copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders and any other expenses not covered. In- and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.
- Deductible, coinsurance and copay waived.
- See back for additional details and benefit limitations.

**Note: Plan overview complements the IAC Personal Health Plans brochure. See Certificate of Coverage for details.**

### Outpatient Prescription Drug Options

#### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

#### Option 2

Not applicable

#### Option 3

#### Copay

Generic \$30

Formulary, non-formulary and specialty drugs available with discount card.

*Discount Card is not an insurance benefit.*

#### Option 4

#### Copay

Generic \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

#### Option 5

#### Copay

Generic \$30  
Formulary \$50\*  
Non-Formulary \$75\*  
Specialty Drugs \$100\*

\*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

#### Option 6

#### Copay

Generic \$30  
Formulary \$50\*\*  
Non-Formulary \$75\*\*  
Specialty Drugs \$100\*\*

\*\*\$1000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Administered by:



Medical insurance underwritten by:



## Exclusions

### CONSULT THE CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF THE CHARGES, SERVICES AND SUPPLIES EXCLUDED FROM COVERAGE.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

Any service or supply in connection with the implant of an artificial organ

Any treatment, service, supply or prescription medication which:

- a) is not due to a sickness or injury;
- b) is not recommended by a physician or
- c) is not medically necessary

Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider

Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day

Any injury or sickness which arises out of or in the course of any employment for wage or profit

An injury or sickness incurred while on active duty with the military of any country or international organization; or resulting from war or any act of war or the participation in a riot or insurrection

Treatment, services or supplies for any loss sustained, incurred due to or contracted as a consequence of a covered person:

- a) being intoxicated;
- b) being under the influence of any narcotic, barbiturate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage or
- c) being under the influence of any illegal drug as defined by state or federal law

Treatment, services or supplies related to the teeth, gums and any other associated structures

Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction

Treatment, services or supplies for:

- a) breast augmentation;
- b) the removal of breast implants and
- c) breast reduction surgery unless medically necessary due to a sickness

Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses

Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion

A newborn's well-baby charges including hospital expenses and nursery charges

Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane

Treatment, services or supplies for inpatient chemical dependency disorders

Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco

Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails

Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies

Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery

Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person

Private duty nursing or custodial care

Inpatient personal convenience items

Telephone and e-mail consultations or missed appointment fees

Treatment, services or supplies received or purchased outside the United States, unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services and supplies used in connection with the urgent care are approved for use in the United States

Treatment, services or supplies for complications of conditions that are not covered under the policy

Non-emergency care ambulance services, durable medical equipment that exceeds \$1,000 and certain prescription medications, unless pre-determined

Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy

Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

# IAC Personal Health Plans - Value Plan

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	80%	50%
Individual Calendar-Year Out-of-Pocket Maximum <sup>1</sup>	\$6,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Physician Charge at Office Visit <i>Other covered services performed are subject to deductible and coinsurance.</i> Limit 2 visits per calendar year	\$40 copay	Deductible and 50% Coinsurance
Routine Mammography <sup>2</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	\$100 Copay, then Deductible and Coinsurance	\$100 Copay, then Deductible and 50% Coinsurance
Ambulance \$500 maximum benefit per calendar year	Deductible and 80% Coinsurance	
<b>OUTPATIENT</b>		
Diagnostic Lab, X-ray and Tests Limit 2 visits per calendar year	\$40 copay, then 100%	Deductible and 50% Coinsurance
Diagnostic Imaging including MRI, CT, and Nuclear Imaging Limit \$500 per calendar year	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Surgical Services Limit \$20,000 maximum per calendar year	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>3</sup>	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental, Nervous and Chemical Dependency Care <sup>3</sup>	Deductible and 50% Coinsurance	Deductible and 50% Coinsurance
<b>INPATIENT</b>		
Surgical Services and Confinement	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental and Nervous Care <sup>3</sup>	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance

1. Does not include medical and Rx deductibles, copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders and any other expenses not covered. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

2. Deductible, coinsurance and copay waived.

3. See back for additional details and benefit limitations.

**Note: Plan overview complements the IAC Personal Health Plans brochure. See Certificate of Coverage for details.**

### Outpatient Prescription Drug Options

#### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

#### Option 2

Not applicable

#### Option 3

#### Copay

Generic \$30

Formulary, non-formulary and specialty drugs available with discount card.

*Discount Card is not an insurance benefit.*

#### Option 4

#### Copay

Generic \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

#### Option 5

#### Copay

Generic \$30  
Formulary \$50\*  
Non-Formulary \$75\*  
Specialty Drugs \$100\*

\*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

#### Option 6

#### Copay

Generic \$30  
Formulary \$50\*\*  
Non-Formulary \$75\*\*  
Specialty Drugs \$100\*\*

\*\*\$1000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Administered by:



Medical insurance underwritten by:



## Exclusions

### CONSULT THE CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF THE CHARGES, SERVICES AND SUPPLIES EXCLUDED FROM COVERAGE.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

Any service or supply in connection with the implant of an artificial organ

Any treatment, service, supply or prescription medication which:

- a) is not due to a sickness or injury;
- b) is not recommended by a physician or
- c) is not medically necessary

Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider

Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day

Any injury or sickness which arises out of or in the course of any employment for wage or profit

An injury or sickness incurred while on active duty with the military of any country or international organization; or resulting from war or any act of war or the participation in a riot or insurrection

Treatment, services or supplies for any loss sustained, incurred due to or contracted as a consequence of a covered person:

- a) being intoxicated;
- b) being under the influence of any narcotic, barbituate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage or
- c) being under the influence of any illegal drug as defined by state or federal law

Treatment, services or supplies related to the teeth, gums and any other associated structures

Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction

Treatment, services or supplies for:

- a) breast augmentation;
- b) the removal of breast implants and
- c) breast reduction surgery unless medically necessary due to a sickness

Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses

Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion

A newborn's well-baby charges including hospital expenses and nursery charges

Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane

Treatment, services or supplies for inpatient chemical dependency disorders

Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco

Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails

Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies

Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery

Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person

Private duty nursing or custodial care

Inpatient personal convenience items

Telephone and e-mail consultations or missed appointment fees

Treatment, services or supplies received or purchased outside the United States, unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services and supplies used in connection with the urgent care are approved for use in the United States

Treatment, services or supplies for complications of conditions that are not covered under the policy

Non-emergency care ambulance services, durable medical equipment that exceeds \$1,000 and certain prescription medications, unless pre-determined

Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy

Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$250 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$50 per visit, combined maximum 10 visits up to \$500 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 5 inpatient days, up to \$1,000 per calendar year in- or out-of-network.

# IAC Personal Health Plans - Copay Plan

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible Must be satisfied before any copays apply	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	100%	70%
Individual Calendar-Year Out-of-Pocket Maximum <sup>1</sup>	Individual: Medical Services and Outpatient Surgical Services & Supplies: \$0 Individual: Inpatient Confinement & Surgical Services: <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000 <sup>3</sup> Family: 3x individual	Individual: Medical Services and Outpatient Surgical Services & Supplies: \$10,000 <sup>2</sup> Individual: Inpatient Confinement & Surgical Services: 3x In-network <sup>3</sup> Family: 3x individual
Physician Office Visit	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
Routine Mammography <sup>4</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	Deductible, then \$200 Copay per occurrence	Deductible, then \$400 Copay per occurrence, then 70% Coinsurance
Ambulance	Deductible, then \$200 Copay per occurrence	
<b>OUTPATIENT</b>		
Diagnostic Lab, X-ray and Tests including MRI, CT, and Nuclear Imaging	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>5</sup>	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
Mental, Nervous and Chemical Dependency Care <sup>5</sup>	Deductible, then \$40 Copay, then 50% Coinsurance	Deductible, then \$70 Copay, then 50% Coinsurance
Surgical Services: Hospital or Ambulatory Facility	Deductible, then \$200 Copay per visit	Deductible, then \$400 Copay per visit, then 70% Coinsurance
Surgery and Anesthesiology	Deductible, then \$500 Copay per visit	Deductible, then \$750 Copay per visit, then 70% Coinsurance
<b>INPATIENT</b>		
Surgical Services and Confinement	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance
Skilled Nursing	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance
Mental and Nervous Care <sup>5</sup>	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance

1. Does not include medical and Rx deductibles, outpatient copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders, inpatient coinsurance and any other expenses not covered. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

2. Only outpatient coinsurance applies to out-of-network out-of-pocket.

3. Only inpatient confinement and surgical services copays apply to out-of-pocket maximum.

4. Deductible, coinsurance and copay waived.

5. See back for additional details and benefit limitations.

## Outpatient Prescription Drug Options

### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

### Option 2

Not applicable

### Option 3

### Copay

Generic \$30

Formulary, non-formulary and specialty drugs available with discount card.

*Discount Card is not an insurance benefit.*

### Option 4

### Copay

Generic \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

### Option 5

### Copay

Generic \$30  
 Formulary \$50\*  
 Non-Formulary \$75\*  
 Specialty Drugs \$100\*

\*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

### Option 6

### Copay

Generic \$30  
 Formulary \$50\*\*  
 Non-Formulary \$75\*\*  
 Specialty Drugs \$100\*\*

\*\*\$1000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Administered by:



Medical insurance underwritten by:



Note: Plan overview complements the IAC Personal Health Plans brochure. See Certificate of Coverage for details.

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## Exclusions

### CONSULT THE CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF THE CHARGES, SERVICES AND SUPPLIES EXCLUDED FROM COVERAGE.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

Any service or supply in connection with the implant of an artificial organ

Any treatment, service, supply or prescription medication which:

- a) is not due to a sickness or injury;
- b) is not recommended by a physician or
- c) is not medically necessary

Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider

Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day

Any injury or sickness which arises out of or in the course of any employment for wage or profit

An injury or sickness incurred while on active duty with the military of any country or international organization; or resulting from war or any act of war or the participation in a riot or insurrection

Treatment, services or supplies for any loss sustained, incurred due to or contracted as a consequence of a covered person:

- a) being intoxicated;
- b) being under the influence of any narcotic, barbituate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage or
- c) being under the influence of any illegal drug as defined by state or federal law

Treatment, services or supplies related to the teeth, gums and any other associated structures

Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction

Treatment, services or supplies for:

- a) breast augmentation;
- b) the removal of breast implants and
- c) breast reduction surgery unless medically necessary due to a sickness

Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses

Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion

A newborn's well-baby charges including hospital expenses and nursery charges

Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane

Treatment, services or supplies for inpatient chemical dependency disorders

Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco

Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails

Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies

Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery

Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person

Private duty nursing or custodial care

Inpatient personal convenience items

Telephone and e-mail consultations or missed appointment fees

Treatment, services or supplies received or purchased outside the United States, unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services and supplies used in connection with the urgent care are approved for use in the United States

Treatment, services or supplies for complications of conditions that are not covered under the policy

Non-emergency care ambulance services, durable medical equipment that exceeds \$1,000 and certain prescription medications, unless pre-determined

Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy

Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$250 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$50 per visit, combined maximum 10 visits up to \$500 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 5 inpatient days, up to \$1,000 per calendar year in- or out-of-network.

# IAC Personal Health Plans - Premier Plan

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Daily Deductibles <sup>1</sup> <i>Maximum of 2 per family</i>	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	3x In-network
Coinsurance	Deductible then 100%	Deductible then 100%
Individual Calendar-Year Out-of-Pocket Maximum <sup>2</sup> <i>Maximum of 2 per family</i>	<input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000	2x In-network
Physician Charge at Office Visit <i>Other covered services performed are subject to daily deductible and coinsurance.</i>	\$40 copay then 100% <b>or</b> Deductible then 100%	Deductible then 100%
Routine Mammography <sup>3</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room	Deductible then 100%	Deductible then 100%
Ambulance	Deductible then 100%	
<b>OUTPATIENT</b> Diagnostic Lab, X-ray and Tests	Deductible then 100%	Deductible then 100%
MRI, CT, and Nuclear Imaging	Deductible then 100%	Deductible then 100%
Surgery	Deductible then 100%	Deductible then 100%
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>4</sup>	Deductible then 100%	Deductible then 100%
Mental, Nervous and Chemical Dependency Care <sup>4</sup>	Deductible then 100%	Deductible then 100%
<b>INPATIENT</b> Surgical Services and Confinement	Deductible then 100%	Deductible then 100%
Mental and Nervous Care <sup>4</sup>	Deductible then 100%	Deductible then 100%

- Does not include Rx deductibles, copays, pre-certification penalty amounts and any other expenses not covered. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied.
- Out-of-pocket maximum includes daily deductible amounts; and excludes Rx deductibles, copays, pre-certification penalty amounts and any other expenses not covered. In-network and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.
- Daily deductible and copay waived.
- See back for additional details and benefit limitations.

**Note: Plan overview complements the IAC Personal Health Plans brochure. See Certificate of Coverage for details.**

### Outpatient Prescription Drug Options

#### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

#### Option 2

Not applicable

#### Option 3

Generic Copay \$30

Formulary, non-formulary and specialty drugs available with discount card.

*Discount Card is not an insurance benefit.*

#### Option 4

Not applicable

#### Option 5

Generic Copay \$30  
Formulary \$50\*  
Non-Formulary \$75\*  
Specialty Drugs \$100\*

\*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

#### Option 6

Generic Copay \$30  
Formulary \$50\*\*  
Non-Formulary \$75\*\*  
Specialty Drugs \$100\*\*

\*\*\$1000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Administered by:



Medical insurance underwritten by:



## Exclusions

### CONSULT THE CERTIFICATE OF COVERAGE FOR A COMPLETE DESCRIPTION OF THE CHARGES, SERVICES AND SUPPLIES EXCLUDED FROM COVERAGE.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

Any service or supply in connection with the implant of an artificial organ

Any treatment, service, supply or prescription medication which:

- a) is not due to a sickness or injury;
- b) is not recommended by a physician or
- c) is not medically necessary

Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider

Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day

Any injury or sickness which arises out of or in the course of any employment for wage or profit

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Treatment, services or supplies related to the teeth, gums and any other associated structures

Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction

Treatment, services or supplies for:

- a) breast augmentation;
- b) the removal of breast implants and
- c) breast reduction surgery unless medically necessary due to a sickness

Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses

Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion

A newborn's well-baby charges including hospital expenses and nursery charges

Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane

Treatment, services or supplies for inpatient chemical dependency disorders

Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco

Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails

Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies

Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery

Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person

Private duty nursing or custodial care

Inpatient personal convenience items

Telephone and e-mail consultations or missed appointment fees

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Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy

Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$1,250 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

# IAC Personal Health Plans - HDHP

## Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Calendar-Year Deductible	Individual: <input type="checkbox"/> \$1,800 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500 <sup>1</sup> <input type="checkbox"/> \$5,250 <sup>1</sup>  Family: <input type="checkbox"/> \$3,600 <input type="checkbox"/> \$5,450 <input type="checkbox"/> \$7,000 <sup>1</sup> <input type="checkbox"/> \$10,500 <sup>1</sup>	Individual: 3x In-network Family: 3x In-network
Coinsurance Options	<input type="checkbox"/> 100% <input type="checkbox"/> 80%	70% 50%
Individual Calendar-Year Out-of-Pocket Maximum <sup>2</sup>	100% Plans Selected Deductible	100% Plans <b>Individual</b> If In-Network Deductible is: Out-of-Pocket is: \$1,800 \$12,000 \$2,700 \$14,700 \$3,500 \$15,500 \$5,250 \$16,500 <b>Family</b> If In-Network Deductible is: Out-of-Pocket is: \$3,600 \$22,000 \$5,450 \$25,000 \$7,000 \$28,000 \$10,500 \$32,000  80% Plans Individual: \$5,250 Family: \$10,500
Physician Charge at Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Routine Mammography <sup>3</sup>	100% of Covered Charges	100% of Covered Charges
Emergency Room	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance	Deductible and Coinsurance	
<b>OUTPATIENT</b> Diagnostic Lab, X-ray and Tests	Deductible and Coinsurance	Deductible and Coinsurance
MRI, CT, and Nuclear Imaging	Deductible and Coinsurance	Deductible and Coinsurance
Surgery	Deductible and Coinsurance	Deductible and Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment <sup>4</sup>	Deductible and Coinsurance	Deductible and Coinsurance
Mental, Nervous and Chemical Dependency Care <sup>4</sup>	Deductible and Coinsurance	Deductible and Coinsurance
<b>INPATIENT</b> Surgical Services and Confinement	Deductible and Coinsurance	Deductible and Coinsurance
Mental and Nervous Care <sup>4</sup>	Deductible and Coinsurance	Deductible and Coinsurance

### Outpatient Prescription Drug Options

#### Option 1

Provides a discount on prescription drug purchases at participating Express Scripts pharmacies.

*This is not an insurance benefit.*

#### Option 2

All covered drugs are subject to calendar-year medical deductible, coinsurance and out-of-pocket.

1. These deductibles not available on the 80% plans.
2. Calendar-year deductible amounts and in- and out-of-network coinsurance amounts combine toward calendar-year out-of-pocket maximum. Does not include pre-certification penalties and any other expenses not covered.
3. Deductible and coinsurance waived.
4. See back for additional details and benefit limitations.

Administered by:



Medical insurance underwritten by:



SSL HDHP 11-08

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Charges incurred after coverage under the policy terminates, regardless of when the condition originated

Charges in excess of the usual and reasonable charges

## Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

## Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

## Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.