

# 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

## Outpatient Prescription Drug Options

### Option 1

Provides a discount on prescription drug purchases at participating 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

Generic Copay \$30

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

### 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\*\*

\*\*\$1,000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

<sup>1</sup> 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.

<sup>2</sup> Only outpatient coinsurance applies to out-of-network out-of-pocket.

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

<sup>4</sup> Deductible, coinsurance and copay waived.

<sup>5</sup> See back for additional details and benefit limitations.

**Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.**



Medical insurance underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group

## 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 that:

- 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

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