

BASE-LEVEL PREMIUM RATES

Deductible applies to all services first.



PERSONAL IHC MED™ A Product of IHC Health Plans

Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx			\$1,000 Medical \$400 Rx			\$2,500 Medical \$1,000 Rx		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
0 - 19	66	118	173	55	98	144	48	86	126	39	71	104
20 - 24	70	133	186	58	111	154	51	97	135	42	80	111
25 - 29	80	152	231	67	126	192	58	110	168	48	91	138
30 - 34	83	156	252	69	130	210	60	113	183	50	94	151
35 - 39	89	159	288	74	132	240	65	115	210	53	95	173
40 - 44	102	187	337	85	155	280	74	136	245	61	112	202
45 - 49	119	222	381	99	185	316	86	162	277	71	133	228
50 - 54	136	264	402	113	219	334	99	192	292	82	158	241
55 - 59	162	324	439	135	269	365	118	236	319	97	194	264
60 - 64	198	400	512	164	333	426	144	291	372	119	240	307



PERSONAL SELECTMED™ A Product of IHC Health Plans

Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx			\$1,000 Medical \$400 Rx			\$2,500 Medical \$1,000 Rx		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
0 - 19	71	128	188	61	109	160	55	98	144	44	79	116
20 - 24	76	145	202	65	124	172	58	111	155	47	90	125
25 - 29	87	165	251	74	141	214	67	126	192	54	102	155
30 - 34	90	170	274	77	145	234	69	130	210	56	105	170
35 - 39	97	173	313	83	147	268	74	132	240	60	107	194
40 - 44	111	203	366	95	174	313	85	156	281	69	126	227
45 - 49	129	242	414	110	206	353	99	185	317	80	150	256
50 - 54	148	287	437	126	245	374	114	220	335	92	178	271
55 - 59	177	352	477	151	301	408	135	270	366	109	218	295
60 - 64	215	435	557	184	372	476	165	334	427	133	269	345



PERSONAL IHC CARE™ A Product of IHC Health Plans

Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx			\$1,000 Medical \$400 Rx			\$2,500 Medical \$1,000 Rx		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
0 - 19	85	152	223	73	132	193	66	118	174	53	95	139
20 - 24	90	172	240	78	149	208	70	134	187	56	108	150
25 - 29	104	196	298	90	170	258	81	153	232	65	122	186
30 - 34	107	202	326	92	174	282	83	157	254	67	126	204
35 - 39	115	205	373	100	178	322	90	160	290	72	128	233
40 - 44	132	242	436	114	209	377	103	188	339	83	151	272
45 - 49	153	288	492	133	249	426	119	224	383	96	179	307
50 - 54	176	341	520	152	295	450	137	266	405	110	213	325
55 - 59	210	419	568	182	362	491	163	326	442	131	262	354
60 - 64	256	518	663	221	448	573	199	403	515	160	323	413

MID-LEVEL PREMIUM RATES

No deductible for office visits. With deductible for Rx.



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Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx		
	Single	2-Party	Family	Single	2-Party	Family
0 - 19	75	134	196	64	114	167
20 - 24	79	151	211	67	129	179
25 - 29	91	172	262	78	147	223
30 - 34	94	177	286	80	151	244
35 - 39	101	180	327	86	153	279
40 - 44	116	212	382	99	181	326
45 - 49	134	252	432	115	215	368
50 - 54	155	300	456	132	255	389
55 - 59	184	368	498	157	313	424
60 - 64	224	454	581	191	387	495



PERSONAL SELECTMED™

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Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx		
	Single	2-Party	Family	Single	2-Party	Family
0 - 19	80	143	210	71	128	187
20 - 24	85	162	226	75	144	201
25 - 29	98	185	281	87	164	250
30 - 34	101	190	307	89	169	273
35 - 39	109	193	351	97	172	312
40 - 44	125	228	410	111	203	365
45 - 49	144	271	464	128	241	412
50 - 54	166	322	490	148	286	436
55 - 59	198	395	535	176	351	476
60 - 64	241	488	624	214	434	555



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Deductibles Age	\$250 Medical \$100 Rx			\$500 Medical \$200 Rx		
	Single	2-Party	Family	Single	2-Party	Family
0-19	96	172	253	85	152	223
20 - 24	102	195	271	90	172	240
25 - 29	117	222	337	104	196	298
30 - 34	121	228	369	107	202	326
35 - 39	130	232	422	115	205	372
40 - 44	150	273	493	132	241	435
45 - 49	173	325	557	153	287	492
50 - 54	199	386	588	176	341	519
55 - 59	237	474	642	210	418	567
60 - 64	289	585	749	255	517	661

HIGH-LEVEL PREMIUM RATES

No deductible for office Visits. No deductible for Rx.



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Deductible	\$250 Medical			\$500 Medical			\$1,000 Medical		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
Age									
0 - 19	83	149	219	71	127	187	65	116	169
20 - 24	88	169	235	75	144	201	68	131	182
25 - 29	102	192	292	87	164	249	79	149	226
30 - 34	105	198	320	89	169	273	81	153	247
35 - 39	113	201	366	96	172	312	87	156	283
40 - 44	130	237	427	111	202	364	100	183	331
45 - 49	150	282	483	128	240	411	116	218	373
50 - 54	173	335	510	147	285	435	134	259	395
55 - 59	206	411	557	176	350	475	159	318	431
60 - 64	251	508	649	214	433	554	194	393	503



PERSONAL SELECTMED™

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Deductible	\$250 Medical			\$500 Medical			\$1,000 Medical		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
Age									
0 - 19	89	160	235	80	143	209	73	130	191
20 - 24	95	181	253	84	161	225	77	147	205
25 - 29	109	206	314	97	184	279	89	168	255
30 - 34	112	212	343	100	189	306	91	173	279
35 - 39	121	216	392	108	192	349	99	176	319
40 - 44	139	254	459	124	227	408	113	207	373
45 - 49	161	303	518	144	269	461	131	246	421
50 - 54	185	359	547	165	320	487	151	292	445
55 - 59	221	441	598	197	393	532	180	358	486
60 - 64	269	545	697	240	485	621	219	443	567



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Deductible	\$250 Medical			\$500 Medical			\$1,000 Medical		
	Single	2-Party	Family	Single	2-Party	Family	Single	2-Party	Family
Age									
0 - 19	107	192	282	95	170	249	88	157	231
20 - 24	114	218	303	100	193	268	93	178	248
25 - 29	131	248	377	116	219	333	107	202	308
30 - 34	135	255	412	119	225	364	110	208	337
35 - 39	146	259	471	129	229	417	119	212	385
40 - 44	167	305	551	148	270	487	137	250	450
45 - 49	194	363	622	171	321	550	158	297	508
50 - 54	222	431	657	197	381	581	182	352	537
55 - 59	265	529	718	235	468	634	217	433	586
60 - 64	323	654	837	286	578	740	264	534	684



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You Must Use Participating Providers (Except for Emergencies)

CONDITIONS and LIMITATIONS

Lifetime Maximum Plan Payment – Per Person	None
Pre-Existing Conditions and Limitations	Not covered first 12 months
Waived (entirely or partially) for qualifying pre-existing condition credit	

MEDICAL DEDUCTIBLE and MEDICAL OUT-OF-POCKET

Member Pays

Calendar Year Deductible and Out-of-Pocket Amounts* You have chosen one of the following deductible options; see your ID Card to find out which deductible option applies to you. <i>Deductible included in the out-of-pocket maximum.</i>	Person/Family	
	Deductible	Out-of-Pocket
\$250 Deductible*	\$250/\$750	\$2,500/\$5,000
\$500 Deductible*	\$500/\$1,000	\$3,000/\$6,000
\$1,000 Deductible*	\$1,000/\$2,000	\$3,500/\$7,000
\$2,500 Deductible*	\$2,500/\$5,000	\$4,000/\$8,000

INPATIENT SERVICES

Member Pays

Medical, Surgical, Emergency Admissions	20% after deductible
Semi-private room, board, anesthesia, and all related services	
Maternity	Covered at 100%
Includes all related maternity services after calendar year maternity deductible	
Enroll in the IHC Healthy Beginnings SM program: 1-866-442-5052	
Skilled Nursing Facility	20% after deductible
Up to 60 days/calendar year	

OUTPATIENT SERVICES

Member Pays

Outpatient and Ambulatory Surgical Facility	20% after deductible
Includes all related services	
Emergency Room Participating Facility	\$25 plus 20% after deductible
Emergency Room Nonparticipating Facility	\$75 plus 20% after deductible
IHC InstaCare SM Facility	\$25 after deductible ¹
IHC KidsCare SM Facility	\$15 after deductible ¹
Chemotherapy, Radiation, and Dialysis	20% after deductible
Diagnostic Tests, Minor Outpatient (See Professional Services, Office Visits)	Covered at 100% after deductible ¹
Except when charges for minor diagnostic tests are incurred in connection with an inpatient or outpatient admission to a facility or as a result of an ER visit, the benefit level for those specific services will apply.	
Diagnostic Tests, Major Outpatient	20% after deductible
Including, but not limited to: CT scans, MRI/NMRs, neurologic, and cardiovascular diagnostics	

PROFESSIONAL SERVICES

Member Pays

Office Visits, Minor Surgeries, and Minor Diagnostic Tests	
Primary Care Physician ⁴	\$15 after deductible ¹
Secondary Care Physician ⁴	\$15 after deductible ¹
After hours	\$25 after deductible ¹
Major Surgery	20% after deductible
Surgical and endoscopic procedures outside the physician's office setting	

PROFESSIONAL SERVICES, continued

Member Pays

Infertility (<i>Select services only</i>)	50% after deductible ²
Maximum plan payment: \$1,500/calendar year; \$5,000/lifetime	
Physician's Fees – Medical, Surgical, Anesthesiologist	20% after deductible
Mental Health and Chemical Dependency	
Inpatient	50% after deductible ²
Up to 10 days/calendar year	
Outpatient	50% after deductible ²
Up to 15 visits/calendar year	
Chiropractic	<i>Not covered</i>
Rehabilitation Therapy	
Inpatient – physical, speech, and occupational therapy	20% after deductible
Up to 40 days/calendar year	
<i>Limit applies to physical, speech, and occupational therapies combined</i>	
Outpatient – physical, speech, and occupational therapy	\$15 after deductible
Up to 20 visits/calendar year	
<i>Limit applies separately for each therapy type listed</i>	

MISCELLANEOUS SERVICES

Member Pays

Supplemental Accident	1 st \$1,000 covered at 100%
Per person/calendar year	<i>Deductible and coinsurance apply thereafter</i>
Adoption Indemnity Benefit	Plan pays: \$3,155
Ambulance (Air) – (<i>emergencies only</i>)	20% after deductible
Ambulance – (<i>emergencies and urgent conditions only</i>)	20% after deductible
Durable Medical Equipment (DME)	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Injectable Drugs	20% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible
Allergy Tests	\$15 after deductible ¹
Allergy Treatment and Serum	20% after deductible ¹
Preventive Care	<i>See Office Visits</i>
Includes routine exams; family planning; hearing and vision exams; and minor tests	
Immunizations – Adult/Pediatric	<i>Covered at 100%</i>

OPTIONAL BENEFIT RIDERS

Member Pays

You have selected one of the options listed for prescription drugs. If you have selected the Base- or Mid-level plan, you have option ❶. If you have selected the High-level plan, you have option ❷.

❶ Prescription Drug with Rx Deductible*

\$4000

Rx Out-of-Pocket Maximum

\$5 after Rx deductible

Generic

25% after Rx deductible

Preferred Brand Name

50% after Rx deductible

Non-Preferred Brand Name

Up to a 30-day supply for covered medications; generic substitution required; mail order (90-day supply) included, same copay/coinsurance applies to a 90-day mail order supply.

Rx Deductibles

If your medical deductible is:
Then your Rx deductible per person/per calendar year (applied to Rx out-of-pocket maximum) is:

\$250	\$500	\$1,000	\$2,500
\$100	\$200	\$400	\$1,000

❷ Prescription Drug with Rx Deductible Waiver*

Rx deductible is waived

FOOTNOTES

- The deductible will not apply when you have selected the Mid- or High-level plans.
- Not applied to out-of-pocket maximum. Benefit level does not change even when the out-of-pocket maximum has been met.
- Refer to the Contract for more information.
- Refer to your IHC Health Plans Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Physician.

*You have selected one of these options; see a copy of your application or ID Card if you have questions about which options you have selected.