



P.O. Box 1090
Great Bend, KS 67530
(877) 793-6880
Fax: (620) 793-1199
www.HIPIOWA.com

Administered by Benefit Management, LLC

IMPORTANT NOTICE

- Re:
- **Premium Rates Effective January 1, 2023**
 - **Coverage Options for 2023**
 - **How to Renew Your HIPIOWA Coverage or Buy New Coverage for 2023**

Your Current Plan is:

<plan>

Dear Member:

This letter contains important information about your **premium rates effective January 1, 2023**, and **how to renew your HIPIOWA plan or purchase new coverage for 2023**.

You can **keep your HIPIOWA coverage or obtain new coverage outside of HIPIOWA**. Several key provisions of the Affordable Care Act (ACA) went into effect in 2014 that changed health coverage for individuals and families. These changes provide HIPIOWA enrollees with additional options for coverage since insurance companies are no longer able to deny coverage or charge more in premium if you have a pre-existing condition. **HIPIOWA** premiums may continue to be higher than premiums in the market, so we strongly encourage you to look at these new options. Please read this information carefully and contact us at 1-877-793-6880 if you have any questions or need assistance.

2023 HIPIOWA Premium Rates

Your HIPIOWA monthly premium rate will not change for 2023. By law, we are required to base our rates on what other carriers in the state charge for similar benefits. Please consult the enclosed rate chart and your corresponding age to confirm your rate.

Coverage Options for 2023

You may continue to renew your coverage with HIPIOWA or obtain new coverage through the Marketplace. The 2023 Open Enrollment Period runs through **December 15, 2022**.

You can preview plans and prices by visiting <https://www.healthcare.gov/see-plans>. This will help you compare the plans and premiums **HIPIOWA** currently offers with the available Marketplace plans.

Open Enrollment Timeline for the Marketplace

- **November 1, 2022:** Open Enrollment started – first day to enroll for a 2023 insurance plan through the Health Insurance Marketplace.
- **December 15, 2022:** Last day to enroll in or change plans for 2023 coverage that starts January 1, 2023.
- **January 1, 2023:** 2023 coverage starts, if you have enrolled by December 15, 2022, and paid your first premium.

Here are some important things to know about your 2023 coverage options:

- **You can keep your HIPIOWA coverage, or you may want to explore obtaining new coverage through the Marketplace - or directly from an insurance company.**
 - You cannot be turned down or charged more because you have a pre-existing condition.
 - New coverage may only be purchased during the open enrollment period which ends on December 15, 2022.
 - You may find new coverage that meets your needs at a lower cost than **HIPIOWA**. These savings may be even greater if you qualify for federal tax credits or financial help available for coverage purchased through the Marketplace.
- You may be eligible for coverage through Iowa Medicaid or the Iowa Health and Wellness Plan, the Medicaid program created to provide comprehensive health care coverage. You may visit www.healthcare.gov.
- **Individuals and families can only purchase new coverage during defined open enrollment or special enrollment periods.** (Not to be confused with HIPIOWA's open enrollment period which is the time each year when enrollees verify eligibility and have an opportunity to switch to a different HIPIOWA plan.)
 - The open enrollment period for purchasing new coverage in the Marketplace or from an insurance company in the state of Iowa is **November 1, 2022, through December 15, 2022.**
- **Premium tax credits are only available for coverage purchased through the Marketplace.**
 - Tax credits or financial help are not available for HIPIOWA coverage or coverage purchased directly from an insurance company – they are only available for coverage purchased through the Marketplace and then only if you qualify.

How to Renew Your HIPIOWA Coverage or Buy New Coverage for 2023

Step 1	Review the enclosed HIPIOWA 2023 Monthly Premium Rates.
Step 2	<p>Find out if you are eligible for financial help to purchase new coverage offered through the Marketplace.</p> <p>Contact the Marketplace at 1-800-318-2596 or visit www.healthcare.gov to find out if you qualify for financial help for plans offered through the Marketplace. They will also check to see if you are eligible for Medicaid.</p> <ul style="list-style-type: none"> • If you are eligible for financial help, you may find coverage in the Marketplace that meets your needs at a much lower cost than HIPIOWA coverage. • Financial help is <u>not</u> available for HIPIOWA coverage or coverage purchased directly from an insurance company.
Step 3	<p>Compare your options. Compare your HIPIOWA plan and 2023 premium to other coverage options available through the Marketplace or directly from insurance companies. When comparing plans, be sure to also look at the provider network and prescription drug formulary. Out-of-pocket costs can be substantially higher if you use out-of-network providers or non-formulary prescription drugs.</p> <p>Help is available!</p> <p>Marketplace customer support is available by phone, or in person through local organizations, insurance brokers or agents. Call 1-800-318-2596 or visit www.healthcare.gov.</p> <p>HIPIOWA Customer Service is also available to help answer your questions or direct you to those who can. Call HIPIOWA Customer Service at 1-877-793-6880.</p>
Step 4	<p>To renew your HIPIOWA coverage or switch HIPIOWA plans:</p> <ol style="list-style-type: none"> 1. Fill out and return the enclosed (Green) Eligibility Verification Form <u>by December 15, 2022</u>. 2. If you decide to switch to a different HIPIOWA plan, please make sure that you have marked your choice on the form prior to mailing the form back. <p><u>OR</u></p> <p>To cancel your HIPIOWA coverage and buy new coverage:</p> <ol style="list-style-type: none"> 1. Please contact HIPIOWA Customer Service by mail to let us know you are cancelling your HIPIOWA plan. 2. Contact the Marketplace at 1-800 318-2596 or visit www.healthcare.gov or an insurance company to enroll in new coverage.

Enclosures in the Packet Include:

- **2023 HIPIOWA Premium Rates** – Effective January 1, 2023
- **Eligibility Verification Form** (Green Paper) – For enrollees continuing coverage with HIPIOWA in 2022, this form is **due by December 15, 2022**.
- **HIPIOWA Highlights and Comparison Chart**

If you have questions or need assistance during this year's HIPIOWA open enrollment, please call **HIPIOWA Customer Service** at **1-877-793-6880**. Updated information is also available at our website at **www.HIPIOWA.com**.

Information for the **Marketplace** is available at **www.healthcare.gov** or by calling **1-800-318-2596**.

Iowa Comprehensive Health Association (HIPIOWA)
2023 Monthly Individual Premium Rates with 0.0% Rate Change Over 2022
 Effective 1/1/2023

NonTobacco User Rates

Plan	Plan B		Plan C		Plan D		Plan E		Plan F	
	\$1,000 Deductible		\$1,500 Deductible		\$2,500 Deductible		\$5,000 Deductible		\$10,000 Deductible	
Age / Gender	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0 - 17	\$461.29	\$509.60	\$423.73	\$468.10	\$373.42	\$412.51	\$254.90	\$281.61	\$228.80	\$252.76
18	484.99	577.97	445.50	530.92	392.59	467.88	268.00	319.39	240.56	286.67
19	508.70	646.34	467.27	593.74	411.79	523.22	281.10	357.17	252.31	320.59
20	533.29	714.70	489.91	656.53	431.70	578.57	294.71	394.95	264.52	354.51
21	557.02	783.08	511.66	719.33	450.90	633.92	307.79	432.74	276.27	388.41
22	580.71	851.47	533.42	782.15	470.07	689.28	320.90	470.51	288.04	422.32
23	589.80	872.41	541.82	801.40	477.47	706.23	325.94	482.11	292.56	432.74
24	600.75	897.02	551.87	824.02	486.31	726.15	331.99	495.70	297.99	444.93
25	610.78	920.74	561.06	845.77	494.44	745.35	337.53	508.81	302.95	456.69
26	618.09	935.32	567.77	859.17	500.34	757.14	341.55	516.86	306.57	463.92
27	620.81	935.32	570.28	859.17	502.57	757.14	343.05	516.86	307.93	463.92
28	634.49	966.32	582.85	887.67	513.63	782.23	350.61	533.98	314.71	479.31
29	644.52	982.73	592.06	902.72	521.75	795.52	356.16	543.05	319.70	487.44
30	651.82	990.92	598.75	910.27	527.63	802.17	360.19	547.59	323.30	491.52
31	658.19	996.40	604.62	915.30	532.81	806.59	363.73	550.61	326.46	494.23
32	666.39	1,005.52	612.15	923.66	539.44	813.97	368.24	555.64	330.54	498.75
33	681.89	1,032.87	626.38	948.78	552.00	836.12	376.81	570.78	338.21	512.33
34	697.39	1,059.31	640.62	973.08	564.53	857.53	385.36	585.37	345.93	525.42
35	712.89	1,084.82	654.85	996.51	577.08	878.17	393.95	599.49	353.60	538.09
36	730.21	1,113.10	670.75	1,022.48	591.11	901.05	403.51	615.10	362.19	552.09
37	749.35	1,145.01	688.35	1,051.79	606.62	926.89	414.09	632.72	371.69	567.92
38	778.52	1,161.40	715.15	1,066.87	630.22	940.17	430.21	641.78	386.15	576.06
39	807.71	1,182.38	741.94	1,086.11	653.84	957.13	446.34	653.40	400.63	586.47
40	839.59	1,206.08	771.27	1,107.89	679.66	976.33	463.96	666.48	416.46	598.21
41	873.34	1,227.96	802.24	1,127.98	706.97	994.03	482.60	678.57	433.17	609.07
42	911.63	1,247.09	837.41	1,145.58	737.96	1,009.54	503.77	689.14	452.17	618.57
43	936.24	1,274.44	860.02	1,170.70	757.89	1,031.67	517.35	704.26	464.39	632.14
44	966.32	1,299.07	887.67	1,193.31	782.23	1,051.59	533.98	717.85	479.31	644.34
45	998.23	1,322.76	916.97	1,215.08	808.07	1,070.77	551.62	730.96	495.13	656.09
46	1,031.07	1,347.38	947.10	1,237.70	834.63	1,090.72	569.75	744.56	511.41	668.31
47	1,061.12	1,373.82	974.75	1,261.98	858.99	1,112.11	586.38	759.15	526.34	681.43
48	1,096.67	1,389.29	1,007.41	1,276.21	887.77	1,124.67	606.04	767.75	543.95	689.10
49	1,131.32	1,406.62	1,039.22	1,292.13	915.81	1,138.67	625.18	777.32	561.14	697.68
50	1,165.05	1,424.86	1,070.21	1,308.87	943.12	1,153.42	643.81	787.38	577.87	706.74
51	1,200.60	1,442.18	1,102.88	1,324.77	971.89	1,167.46	663.46	796.97	595.52	715.35
52	1,237.06	1,455.86	1,136.36	1,337.35	1,001.41	1,178.52	683.61	804.51	613.61	722.12
53	1,281.74	1,485.92	1,177.39	1,364.97	1,037.57	1,202.88	708.28	821.13	635.74	737.03
54	1,326.41	1,513.29	1,218.42	1,390.10	1,073.74	1,225.01	732.98	836.26	657.91	750.60
55	1,372.91	1,538.81	1,261.15	1,413.54	1,111.37	1,245.67	758.68	850.35	680.98	763.27
56	1,421.22	1,566.17	1,305.53	1,438.68	1,150.48	1,267.83	785.36	865.46	704.93	776.84
57	1,472.28	1,598.06	1,352.42	1,467.99	1,191.81	1,293.64	813.57	883.10	730.27	792.66
58	1,552.48	1,624.52	1,426.12	1,492.27	1,256.75	1,315.05	857.89	897.70	770.04	805.77
59	1,633.62	1,654.57	1,500.63	1,519.91	1,322.43	1,339.41	902.73	914.34	810.30	820.68
60	1,717.50	1,686.50	1,577.68	1,549.21	1,390.33	1,365.23	949.09	931.96	851.90	836.52
61	1,808.64	1,719.32	1,661.43	1,579.36	1,464.12	1,391.79	999.46	950.08	897.11	852.79
62	1,909.84	1,751.21	1,754.39	1,608.67	1,546.04	1,417.62	1,055.37	967.73	947.30	868.62
63	2,001.92	1,783.13	1,838.96	1,637.97	1,620.56	1,443.46	1,106.25	985.36	992.97	884.45
64	2,098.55	1,816.86	1,927.71	1,668.96	1,698.79	1,470.75	1,159.65	1,003.99	1,040.90	901.18
65+	2,198.82	1,849.68	2,019.83	1,699.12	1,779.97	1,497.33	1,215.07	1,022.14	1,090.63	917.47

Age/Rate is calculated as of age upon enrollment, then attained age on January 1st.

Iowa Comprehensive Health Association (HIPIOWA)
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Tobacco User Rates

Plan	Plan B		Plan C		Plan D		Plan E		Plan F	
	\$1,000 Deductible		\$1,500 Deductible		\$2,500 Deductible		\$5,000 Deductible		\$10,000 Deductible	
Age / Gender	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0 - 17	\$532.79	\$588.60	\$489.41	\$540.67	\$431.30	\$476.48	\$294.42	\$325.26	\$264.27	\$291.95
18	560.15	667.55	514.58	613.20	453.44	540.38	309.54	368.89	277.84	331.11
19	587.54	746.51	539.70	685.75	475.62	604.31	324.67	412.51	291.42	370.28
20	615.95	825.50	565.83	758.29	498.63	668.24	340.39	456.16	305.52	409.47
21	643.35	904.44	590.96	830.82	520.79	732.16	355.50	499.81	319.10	448.60
22	670.72	983.44	616.12	903.39	542.94	796.10	370.63	543.45	332.67	487.79
23	681.24	1,007.65	625.80	925.62	551.48	815.69	376.47	556.83	337.90	499.81
24	693.87	1,036.07	637.42	951.75	561.68	838.70	383.45	572.53	344.18	513.90
25	705.44	1,063.46	648.03	976.88	571.09	860.88	389.84	587.67	349.90	527.47
26	713.88	1,080.30	655.76	992.34	577.91	874.49	394.48	596.97	354.09	535.84
27	717.03	1,080.30	658.67	992.34	580.46	874.49	396.23	596.97	355.66	535.84
28	734.10	1,118.03	674.36	1,027.01	594.25	905.06	405.65	617.82	364.11	554.55
29	746.99	1,138.97	686.20	1,046.27	604.70	922.01	412.78	629.39	370.52	564.94
30	756.75	1,150.47	695.14	1,056.84	612.58	931.31	418.17	635.74	375.34	570.66
31	765.48	1,158.81	703.17	1,064.51	619.64	938.07	423.01	640.37	379.68	574.78
32	776.34	1,171.43	713.14	1,076.07	628.45	948.27	429.00	647.32	385.09	581.04
33	795.78	1,205.37	730.98	1,107.22	644.18	975.74	439.74	666.09	394.71	597.89
34	815.24	1,238.34	748.88	1,137.52	659.96	1,002.44	450.49	684.30	404.39	614.22
35	834.79	1,270.33	766.85	1,166.92	675.77	1,028.33	461.30	701.99	414.07	630.08
36	856.54	1,305.65	786.80	1,199.37	693.39	1,056.93	473.31	721.52	424.84	647.62
37	880.49	1,345.38	808.82	1,235.85	712.79	1,089.10	486.55	743.47	436.73	667.32
38	915.55	1,365.82	841.02	1,254.63	741.13	1,105.64	505.93	754.74	454.12	677.45
39	950.67	1,391.66	873.28	1,278.37	769.57	1,126.56	525.33	769.02	471.53	690.27
40	989.06	1,420.76	908.56	1,305.10	800.64	1,150.11	546.53	785.10	490.60	704.71
41	1,029.68	1,447.75	945.83	1,329.89	833.51	1,171.97	568.98	800.03	510.72	718.09
42	1,075.72	1,471.58	988.14	1,351.80	870.80	1,191.26	594.44	813.20	533.58	729.91
43	1,106.65	1,506.39	1,016.54	1,383.77	895.82	1,219.43	611.52	832.44	548.90	747.19
44	1,144.13	1,538.08	1,050.98	1,412.88	926.16	1,245.09	632.24	849.92	567.49	762.89
45	1,183.90	1,568.78	1,087.54	1,441.09	958.40	1,269.96	654.22	866.91	587.22	778.12
46	1,224.89	1,600.69	1,125.17	1,470.39	991.54	1,295.75	676.86	884.53	607.55	793.95
47	1,262.74	1,634.85	1,159.94	1,501.75	1,022.21	1,323.38	697.78	903.40	626.31	810.90
48	1,309.42	1,658.84	1,202.84	1,523.78	1,059.99	1,342.84	723.60	916.67	649.49	822.77
49	1,355.31	1,685.14	1,244.98	1,547.97	1,097.14	1,364.11	748.96	931.23	672.25	835.83
50	1,400.40	1,712.70	1,286.41	1,573.27	1,133.62	1,386.43	773.86	946.45	694.61	849.49
51	1,447.93	1,739.27	1,330.08	1,597.68	1,172.10	1,407.96	800.14	961.14	718.17	862.71
52	1,496.85	1,761.58	1,375.00	1,618.18	1,211.69	1,426.00	827.17	973.44	742.46	873.75
53	1,556.04	1,803.92	1,429.36	1,657.08	1,259.62	1,460.30	859.86	996.84	771.78	894.76
54	1,615.57	1,843.18	1,484.03	1,693.14	1,307.82	1,492.07	892.77	1,018.54	801.34	914.24
55	1,677.69	1,880.44	1,541.10	1,727.36	1,358.11	1,522.22	927.09	1,039.13	832.13	932.69
56	1,742.43	1,920.11	1,600.57	1,763.80	1,410.48	1,554.35	962.86	1,061.05	864.25	952.40
57	1,810.89	1,965.61	1,663.47	1,805.62	1,465.91	1,591.16	1,000.70	1,086.19	898.24	974.99
58	1,909.55	1,998.13	1,754.12	1,835.49	1,545.80	1,617.50	1,055.23	1,104.17	947.17	991.10
59	2,009.35	2,035.15	1,845.79	1,869.48	1,626.59	1,647.48	1,110.36	1,124.63	996.66	1,009.45
60	2,112.52	2,074.40	1,940.57	1,905.52	1,710.08	1,679.22	1,167.39	1,146.32	1,047.82	1,028.93
61	2,224.63	2,114.77	2,043.56	1,942.61	1,800.86	1,711.91	1,229.34	1,168.61	1,103.44	1,048.93
62	2,349.10	2,154.00	2,157.89	1,978.68	1,901.63	1,743.66	1,298.12	1,190.29	1,165.18	1,068.41
63	2,462.36	2,193.24	2,261.93	2,014.72	1,993.27	1,775.45	1,360.70	1,211.99	1,221.33	1,087.88
64	2,581.23	2,234.72	2,371.09	2,052.82	2,089.51	1,809.03	1,426.37	1,234.90	1,280.29	1,108.45
65+	2,704.56	2,275.10	2,484.38	2,089.91	2,189.36	1,841.71	1,494.52	1,257.22	1,341.48	1,128.47

Age/Rate is calculated as of age upon enrollment, then attained age on January 1st.



Reply to:
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Administered by Benefit Management LLC

**2023 Plan Change & Eligibility
 Verification Form must be returned to
 our office prior to December 15, 2022.**

«First» «Last»
 «Addr»
 «Addr2»
 «City», «ST» «Zip»

Policy Number: «Partic»

1. Are you currently a resident of the State of Iowa? **Yes / No (circle one)**
2. Have you become eligible to participate in Medicare, Medicaid or any other state program?
Yes / No (circle one) If yes, please enter effective date: _____
3. Have you been declared disabled by social security?
Yes / No (circle one) If yes, please enter eligibility date: _____
4. Are you currently *eligible* for employee group insurance or health insurance from any other source?
Yes / No (circle one) If yes, please enter eligibility date: _____
5. Have you used any Tobacco Products in the last 12 months? **Yes / No (circle one)**
6. If any of the above information is incorrect please indicate the correct information below.

Physical Address of your current residence - Required		Mailing Address if different than physical address	
Name		Name	
Address		Address	
City		City	
State & Zip		State & Zip	
Telephone Number: ()		Email Address:	
Cell Number: ()			

Plan Change Request: Your Current Plan is: «Plan»
 If you wish to change your deductible effective January 1, 2023, please indicate below your choice of plan. Please note: You may increase your deductible as high as you feel necessary, but you may not lower your deductible. Please write “no change” if you wish to remain on your current plan.

I request to change to Plan _____ effective January 1, 2023.

This form must be returned to us **prior to December 15, 2022** at the above address if you do elect to change your plan or have changes in your information. For your convenience we have enclosed a self-addressed envelope. As an alternative you may fax this form to us at (620) 793-1199. Please do not respond more than once.

Signature _____

Date of Birth _____ Today's Date _____

HIPIOWA PPO plans 2023

Office use only

Elig

SS

LX

CS

By _____

**Iowa Comprehensive Health Association (ICHA)
Outline of Benefit Plans**

This document is intended for descriptive purposes only.

All benefits are subject to the terms, conditions, limitations, exclusions, deductibles, copayments, and any and all other contract provisions.

Actual contract provisions prevail in the event of conflict with this document.

Feature / Benefit	HIPIOWA PLANS				
	Plan B - \$1000 Deductible	Plan C - \$1500 Deductible	Plan D - \$2500 Deductible	Plan F - \$5000 Deductible	Plan G - \$10,000 Deductible
Coinsurance (In-Network / Out-of-Network)	80% / 60%	80% / 60%	80% / 60%	80% / 60%	100% / 80%
Deductible (In-Network / Out-of-Network)	\$1,000/\$2,000	\$1,500/\$3,000	\$2,500/\$5,000	\$5,000/\$10,000	\$10,000/\$20,000
Stop Loss Limit (Coinsurance Maximum) (In-Network / Out-of-Network)	\$7,500/\$7,500	\$7,500/\$7,500	\$12,500/\$12,500	\$12,500/\$12,500	- / \$12,500
Out-of-Pocket Maximum (OOP) (In-Network / Out-of-Network)* *OOP includes Deductible & Coinsurance	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000	\$7,500/\$15,000	\$10,000/\$22,500
Lifetime Maximum Benefit	\$3 million				
Deductible Carryover Provision	Yes, deductible carryover of expenses in last 90 days of CY				
Pre-Existing Conditions	6 months prior / coverage excluded for 6 months after effective date of policy				
Covered Benefits	Covered Benefits				
	Eligible expenses are payable for the following benefits, and are subject to the deductible and coinsurance unless otherwise noted. Certain benefits may be subject to inside limits as noted.				
Inpatient Medical / Surgical Services					
Hospital room & board [1]	Covered, no limit				
General nursing care	Covered				
Medical and surgical supplies	Covered				
Accidental injury care	Covered				
Hospital intensive care units (including cardiac care etc.)	Covered				
Inpatient physician and professional services	Covered				
Anesthetics and their administration	Covered				
Diagnostic services - lab, X-ray, MRI, electrocardiogram, etc.	Covered				
Chemotherapy and hemodialysis services	Covered				
Drugs and biologicals	Covered				
Dressings and casts	Covered				
Intravenous injections and solutions	Covered				
Skilled Nursing Facility (SNF)	Covered. Covered expenses limited to semi-private room charge with maximum 60 days benefit/CY. Pre-certification required.				
Short-Term Inpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	Covered Covered Covered Covered Covered				
Emergency care	Covered				
Outpatient Medical / Surgical Services					
Doctor's office visits & related expenses, consultations, medical treatments, office surgery	\$20 copay/visit in-network	\$30 copay/visit in-network	\$40 copay/visit in-network	Subject to deductible and coinsurance	Subject to deductible and coinsurance
	Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance.				
Allergy testing and treatment including allergy injections, therapeutic injections	Covered				
Outpatient facility charges (hospital, ambulatory surgical center)	Covered				
Outpatient physician and professional services	Covered				
Medical and surgical supplies	Covered				
Accidental injury care	Covered				
Anesthetics and their administration	Covered				
Diagnostic services - lab, X-ray, MRI, electrocardiogram, etc.	Covered				
Chemotherapy and hemodialysis services	Covered				
Drugs and biologicals	Covered				
Dressings and casts	Covered				
Intravenous injections and solutions	Covered				
Outpatient Physical Rehabilitation (facility charges and physician/professional services) Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Pulmonary Rehabilitation	Covered subject to pre certification. Subject to deductible and coinsurance.				
Emergency care	\$100 copay. Waived if admitted.				
Urgent care facility	\$75 copay				
Mental Health and Chemical Dependency Services					
Mental Health	MHCD combined benefits - In network covg only - subject to deductible and coinsurance.				

**Iowa Comprehensive Health Association (ICHA)
Outline of Benefit Plans**

This document is intended for descriptive purposes only.

All benefits are subject to the terms, conditions, limitations, exclusions, deductibles, copayments, and any and all other contract provisions.

Actual contract provisions prevail in the event of conflict with this document.

Feature / Benefit	HIPIOWA PLANS				
	Plan B - \$1000 Deductible	Plan C - \$1500 Deductible	Plan D - \$2500 Deductible	Plan F - \$5000 Deductible	Plan G - \$10,000 Deductible
Inpatient	Limited to 20 days/year; combined with CD				
Outpatient	Limited to 45 visits/year, combined with CD.				
Chemical dependency (Alcoholism, Substance Abuse)					
Inpatient	Limited to 20 days/year, combined with MH.				
Outpatient	Limited to 45 visits/year, combined with MH.				
Preventive Services					
Well-child care including physical exams, immunizations, and lab	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.				
Adult routine physical	Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum.				
Routine pap smear					
Routine mammogram					
Prostatic specific antigen (PSA) tests					
Lead screening					
Prescription Drugs	Rx copays do NOT apply to OOP max. Mail order copays = 2x retail.				
Prescription Drugs	Drug card with copay = greater of \$10/\$30/\$50 or 25% for all plans, with \$1,000 maximum drug out-of-pocket limit per calendar year. Copay is actual cost of drug if less than computed copay.				
	No separate drug deductible			Separate \$500 Rx deductible	Separate \$1,000 Rx deductible
	Restricted (brand copay when generic is available = generic copay \$10 plus difference in cost between brand and generic).				
Outpatient Contraceptive Services, including prescription drugs/devices	Covered.				
Transplants					
Transplants	Covered, subject to standard limits of plan, but required to receive treatment at "in-network" facility (i.e., centers of excellence, etc.)				
Types of organ or tissue transplants covered: Cornea Heart Heart-lung Kidney Kidney-pancreas Pancreas Liver Liver-pancreas Bone marrow Single lung transplants Double lung transplants Small bowel	Those certified as medically necessary (any transplants not considered experimental are covered).				
Donor-related expenses	Donor-related expenses for surgery and physician visits are covered to same extent benefits available under the policy.				
Transportation/lodging	Not covered				
Maternity					
Complications of pregnancy	Covered				
Routine maternity care, including delivery room, pre-natal and post-natal care	Optional Rider, pays up to \$5000 covered expenses for normal pregnancy and childbirth including routine hospital and nursing services for newborn child during mother's confinement. Not subject to policy's deductible or coinsurance provisions.				
Other Covered Services					
Ambulance Services (air or ground)	Covered				
Home Health Care	40 visits per calendar year.				
Hospice Care	Covered. Counseling for immediate family covered subject to 90 days per family, bereavement counseling for immediate family covered subject to \$250 maximum.				
Durable Medical Equipment (DME)	Covered (no limit, must be medically necessary, subject to prior approval)				
Blood administration; oxygen	Covered				
Oxygen and equipment	Covered				
Prosthetic appliances	Covered				
Oral surgery for certain services	Covered				
Home infusion therapy	Covered				
Private duty nursing	Not covered				
Chiropractic care	Subject to rehabilitation limits. Maximum of 15 visits per calendar year. Requires precertification.				
Infertility treatment	Not covered				
Temporomandibular joint syndrome	\$1000 lifetime maximum				
Tubal ligation or vasectomy	Covered				
Dental Treatment for Injury	Covered				
Breast reconstruction after mastectomy surgery	Covered				
Diabetes treatment	Covered				
Diabetes education	Diabetes education program expenses covered at 80% (not subject to deductible).				
Growth therapy treatment	Not covered.				
Services Not Covered					
Sex transformations, penile implants, complications	Not covered				

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Feature / Benefit	HIPIOWA PLANS				
	Plan B - \$1000 Deductible	Plan C - \$1500 Deductible	Plan D - \$2500 Deductible	Plan F - \$5000 Deductible	Plan G - \$10,000 Deductible
Infertility treatment			Not covered		
Sterilization			Covered		
Dental care, surgery, or treatment (except reconstructive surgery due to covered injury is covered)			Not covered		
TMJ or surgery of the jaw except as above			Not covered		
Family planning visits			Not covered		
Nutrition counseling			Not covered		
Routine vision exams			Not covered		
Routine hearing exams			Not covered		
Cosmetic surgery or complications; breast augmentation or reduction			Not covered		
Weight modification; treatment of obesity			Not covered		
Eyeglasses, hearing aids, related exams			Not covered		
Orthopedic shoes, foot inserts, support devices for feet, etc.			Not covered		
Convalescent, rest, or nursing facility care except as provided			Not covered		
Experimental or investigative services, supplies, treatments			Not covered		
Private duty nursing, except for covered HHC or Hospice Care			Not covered		
Acupuncture			Not covered		
Smoking cessation classes			Not covered		
Custodial care expenses			Not covered		
Routine podiatry (treatment of feet)			Not covered		
Biofeedback			Not covered		
Massage therapy			Not covered		
Behavior modification and learning disabilities			Not covered		
Alternative medicine			Not covered		

Footnotes

[1] Semi-private or private if medically necessary