HIPIOWA
Iowa Comprehensive Health Association

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

| Feature / Benefit | **HIPIOWA Carveout Plan**<br>Plan E<br>Medicare Carveout<br>$1000 Deductible |
|---|---|
| Coinsurance | 80% |
| Deductible | $1,000 |
| Stop Loss Limit (Coinsurance Maximum) | $7,500 |
| Out-of-Pocket Maximum (OOP)*<br>*OOP includes Deductible & Coinsurance | $2,500 |
| Lifetime Maximum Benefit | $3 million |
| Benefit Year Definition | Calendar Year (CY) |
| 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**<br>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 et | Covered |
| Inpatient physician and professional services | Covered |
| Anesthetics and their administration | Covered |
| Diagnostic services - lab, X-ray, MRI, | 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)<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cardiac Rehabilitation<br>Pulmonary Rehabilitation | <br>Covered<br>Covered<br>Covered<br>Covered<br>Covered |
| Emergency care | Covered |
| **Outpatient Medical / Surgical Services** | |
| Doctor's office visits & related expenses, consultations, medical treatments, office surgery | No Copay [2] |
| | Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance. |
| Allergy treatment including allergy injections, | Covered |
| Outpatient facility charges (hospital, ambulatory | 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, | 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)<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Cardiac Rehabilitation<br>Pulmonary Rehabilitation | Covered subject to case management and limit of 15 visits/CY. Subject to deductible and coinsurance. |
| Emergency care | No Copay [3] |
| Urgent care facility | No Copay [3] |

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| **Mental Health and Chemical Dependency Services (MHCD)** | |
| **Mental Health (MH)** | MHCD combined benefits - In network coverage only - subject to deductible and coinsurance. |
| Inpatient | Limited to 20 days/year; combined with CD. |
| Outpatient | Limited to 45 visits/year, combined with CD. |
| **Chemical Dependency (CD) (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 services | Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum. |
| Adult routine physical<br>Routine pap smear<br>Routine mammogram<br>Prostatic specific antigen (PSA) tests<br>Lead screening | Limited to in-network only. Not subject to deductible. Subject to coinsurance/out-of-pocket maximum. |
| **Prescription Drugs** | |
| | Not Covered Unless Covered by Medicare |
| **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:<br>Cornea<br>Heart<br>Heart-lung<br>Kidney<br>Kidney-pancreas<br>Pancreas<br>Liver<br>Liver-pancreas<br>Bone marrow<br>Single lung transplants<br>Double lung transplants<br>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. |
| **Maternity** | |
| Complications of pregnancy | Covered |
| Routine maternity benefit | 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. |

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| **Other Covered Services** | |
| Ambulance Services (air or ground) | Covered |
| Home Health Care | Covered, 40 visits per calendar year. |
| Hospice Care | Covered. Counseling for immediate family covered subject to 90 visits 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 |
| Chiropractic care | Subject to rehabilitation limits. |
| Temporomandibular joint syndrome | Covered with a $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. Subject to coinsurance. Not subject to deductible. |
| **Services Not Covered** | |
| Sex transformations, penile implants, complications | Not covered |
| Infertility treatment | Not covered |
| Dental care, surgery, or treatment (except reconstructive surgery due to covered injury) | 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 | Not covered |
| Convalescent, rest, or nursing facility care except as provided above | Not covered |
| Experimental or investigative services, supplies, | Not covered |
| Private duty nursing, except for covered HHC or | 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 |
| Growth therapy treatment | Not covered. |
| Private duty nursing | Not covered |
| Infertility treatment | Not covered |
| Transportation/lodging | Not covered |
| Alternative medicine | Not covered |

Footnotes

[1] Semi-private or private if medically necessary

[2] $20 copay applies when the service is not covered by Medicare

[3] $100 copay applies when the service is not covered by Medicare