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 provisons.
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 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	Covered				
Occupational Therapy	Covered				
Speech Therapy	Covered				
Cardiac Rehabilitation	Covered				
Pulmonary Rehabilitation	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 provisons.
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 calander 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				

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 provisons.

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**
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