



### Outline of Benefit Plans

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<b>HIPIOWA Carveout Plan</b> <b>Plan E</b> <b>Medicare Carveout</b> <b>\$1000 Deductible</b>	
Feature / Benefit	
Coinsurance	80%
Deductible	\$1,000
Stop Loss Limit (Coinsurance Maximum)	\$7,500
Out-of-Pocket Maximum (OOP)* *OOP includes Deductible & Coinsurance	\$2,500
Lifetime Maximum Benefit	N/A
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.
<b>Covered Benefits</b>	
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.	
<b>Inpatient Medical / Surgical Services</b>	
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)	
Physical Therapy	Covered
Occupational Therapy	Covered
Speech Therapy	Covered
Cardiac Rehabilitation	Covered
Pulmonary Rehabilitation	Covered
Emergency care	Covered
<b>Outpatient Medical / Surgical Services</b>	
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)	
Physical Therapy	Covered subject to case management and limit of 15 visits/CY. Subject to deductible and coinsurance.
Occupational Therapy	
Speech Therapy	
Cardiac Rehabilitation	
Pulmonary Rehabilitation	
Emergency care	No Copay [3]
Urgent care facility	No Copay [3]



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<b>Mental Health and Chemical Dependency Services (MHCD)</b>	
<b>Mental Health (MH)</b>	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.
<b>Chemical Dependency (CD) (Alcoholism, Substance Abuse)</b>	
Inpatient	Limited to 20 days/year, combined with MH.
Outpatient	Limited to 45 visits/year, combined with MH.
<b>Preventive Services</b>	
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	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	
<b>Prescription Drugs</b>	
	Not Covered Unless Covered by Medicare
<b>Transplants</b>	
	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.
<b>Maternity</b>	
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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<b>Other Covered Services</b>	
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.
<b>Services Not Covered</b>	
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