



**Outline of Benefit Plans**

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Feature / Benefit	NEW HIPIOWA Plans All Plans Contain Preferred Provider Features			
	Plan A Medicare Carveout \$1000 Deductible	Plan B \$1000 Deductible	Plan C \$1500 Deductible	Plan D \$2500 Deductible
Coinsurance (In-Network / Out-of-Network)	80% / 60%	80% / 60%	80% / 60%	80% / 60%
Deductible (In-Network / Out-of-Network)	\$1,000/\$2,000	\$1,000/\$2,000	\$1,500/\$3,000	\$2,500/\$5,000
Stop Loss Limit (Coinsurance Maximum) (In-Network / Out-of-Network)	\$7,500/\$7,500	\$7,500/\$7,500	\$7,500/\$7,500	\$12,500/\$12,500
Out-of-Pocket Maximum (OOP) (In-Network / Out-of-Network)* *OOP includes Deductible & Coinsurance	\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$6,000	\$5,000/\$10,000
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.			
<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]	\$20 copay/visit in-network	\$30 copay/visit in-network	\$40 copay/visit in-network
	Office visit only. Other services subject to deductible and coinsurance. Out of network subject to deductible and coinsurance.			
Allergy treatment including allergy injections,	Not 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]	\$100 copay. Waived if admitted.		
Urgent care facility	No Copay [3]	\$100 copay.		



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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>				
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. Prescription copays do NOT apply to Out-of-Pocket Max. Mail order (a 90-day supply) copay = 2x retail.			
	No separate drug deductible. Restricted (brand copay when generic is available = generic copay plus difference in cost between brand and generic).			
Outpatient Contraceptive Services, including prescription drugs/devices	Covered.			
<b>Transplants</b>				
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			
<b>Maternity</b>				
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.			



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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			
Private duty nursing	Not covered			
Chiropractic care	Subject to rehabilitation limits.			
Infertility treatment	Not covered			
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.			
Growth therapy treatment	Not covered.			
<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 is	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			
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