



Iowa Comprehensive Health Association

ADMINISTRATOR
Benefit Management, Inc.
2015 16th Street
P.O. Box 1090
Great Bend, KS 67530

PREFERRED PROVIDER POLICY

This policy is issued to You by the Iowa Comprehensive Health Association in accordance with Iowa laws. The premium You paid and the application You completed and Our reliance on Your answers to the application questions have put this policy in force as of the Policy Date. That date is shown on the Schedule. A copy of Your application is attached.

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Table with 2 columns: PAGE NO. and PAGE NO. listing various policy sections and their corresponding page numbers.

PART A. 10-DAY RIGHT TO EXAMINE POLICY

We want You to fully understand and be entirely satisfied with Your policy. If You are not satisfied for any reason, You may return this policy to Us or Your agent within 10 days of its receipt. We will then refund any premiums You have paid and void Your policy as of the date any insurance became effective.

PART B. PLEASE READ APPLICATION

Please read the copy of Your application. If anything in it is not correct or if any past medical history has been left out, You should tell Us. Your policy was issued on the basis that all information in the application is correct and complete. If not, Your policy may not be valid.

PART C. RENEWAL AGREEMENT AND TERMINATION

Your policy will be renewed each time the required premium payment is made.

Coverage will terminate for each person Insured Person under this policy when:

- (a) You are no longer eligible for coverage under the Iowa Comprehensive Health Association;
(b) You become eligible for Medicare based upon age;
(c) You are no longer a resident of the State of Iowa;
(d) 30 days after the date We make inquiry concerning Your place of residence if You do not reply;
(e) You are eligible for public programs for which medical care is provided; or
(f) The date Iowa statutes require cancellation of this policy.

In the event the Insured Person qualifies for other coverage, a certificate of creditable coverage will be produced on behalf of the Insured Person.

If nonrenewed, We will mail notice of nonrenewal to the last address shown on Our records at least 30 days prior to the renewal date and will return any unused premium to You. Your premium must be paid on the date it is due or during the 31-day grace period that follows.

## **PART D. PREMIUM AND POLICY CHANGES**

**PREMIUM CHANGES.** Your premium is expected to change. The change will be based on an Insured Person's attained age or on a revised schedule of rates or both. We can apply revised rates only if We do the same thing on all policies of this Form, with the same provisions and benefits, issued to persons of the same classification in the same geographic area of the State of Iowa. Premium changes will become effective on the first day of the month that coincides with or next follows the effective date of the change. We will notify You 30 days in advance of Your renewal date.

**POLICY CHANGES.** Any provision of this policy, including but not limited to Coinsurance percentages, Deductibles, Stop-Loss Limit, Out-of-Pocket Maximums, Lifetime Maximum, Copayments, and Calendar Year Maximums, are subject to change as determined by the Iowa Comprehensive Health Association. You will receive written notice of any policy changes in advance.

You can change, for the next Calendar Year, to a higher Deductible upon written notification to the Administrator. The effective date of the change will be the next Calendar Year following the date of Your request.

## **PART E. PRE-EXISTING CONDITION LIMITATION**

The benefits of this policy will not be payable for any pre-existing Injury or Sickness for the first six months following the Policy Date. Pre-existing Injury or Sickness means an Injury or Sickness for which medical advice or Treatment was recommended by or received from a Physician within the six-month period prior to the Policy Date.

We will only pay for Expenses incurred after such six-month period. Payment will be in accordance with the provisions of this policy. This limitation does not apply to federally eligible individuals.

## **PART F. DEFINITIONS**

**Administrator** means the entity shown on the Policy Schedule.

**Ambulatory Surgical Facility** means a facility that:

- (1) is operated under the laws of the jurisdiction in which it is located for units of its type;
- (2) is used mainly for performing outpatient surgery;
- (3) has a staff of Physicians;
- (4) has continuous Physician care and registered nursing care by RNs when patients are there; and
- (5) does not provide for overnight stays.

**Calendar Year** begins on January 1 and ends on December 31 of the same year.

**Confinement** means needed confinement as a resident inpatient because of Injuries or Sickness. It must be for a period of at least 12 consecutive hours. A Physician must recommend and supervise the Confinement.

**Center of Excellence** means a specialized premier medical facility which is part of a transplant network organization selected by Us to provide access to the delivery of quality, cost effective organ transplant services.

**Coinsurance** means the applicable percentage payable for covered services by the Insured Person after benefits have been considered by Us in accordance with the percentage payable shown in the Policy Schedule.

**Contraceptives** mean drugs and devices approved by the Federal Food and Drug Administration (FDA) for use in preventing pregnancy.

**Custodial Care** means that type of care which is designed essentially to assist an individual to meet his or her daily living activities and is of a nature that does not require the continuing attention and assistance of licensed medical personnel.

**Donor** means an individual who undergoes a surgical operation for the purpose of donating an internal body organ for Transplant Surgery.

**Durable Medical Equipment** means Medically Necessary equipment that is:

- (a) able to withstand repeated or prolonged use;
- (b) primarily and customarily used to serve a medical purpose;
- (c) not generally useful to a person in the absence of Injury or Sickness; and
- (d) is suited for use in the home.

Durable Medical Equipment includes supplies that are necessary for use with the equipment.

Durable Medical Equipment does not include motor vehicles or any modification that does not serve a direct medical purpose in treating an Injury or Sickness, including but not limited to:

- (a) modification / assisting devices for motor vehicles, (not including motorized wheelchairs or scooters used in lieu of wheelchairs); or
- (b) internal or external structural modifications to building, widening of door frames, replacement doors, ramps, modifications to walkways, stairs or non-bathroom handrails.

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that absence of immediate medical attention to result in one of the following:

- (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- (b) serious impairment to bodily function; or
- (c) serious dysfunction of any bodily organ or part.

**Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an Emergency Medical Condition.

**Expense** means expense incurred for the Medically Necessary Covered Services and Supplies listed in Parts G, H and I. The services and supplies must be ordered or prescribed by a Physician as needed for diagnosis or Treatment. Expense for a service or supply is considered incurred on the date it is received.

Expense does not include any charge:

- (a) for a service or supply otherwise excluded under the policy;
- (b) which is in excess of the charge which the Physician or Hospital has agreed to accept as payment in full;
- (c) for a service or supply which is not Medically Necessary; or
- (d) amounts in excess of the usual and normal charges in the geographic area involved (as determined by Us).

Only Expenses in excess of any workers' compensation, employer's liability or auto No-Fault payments will be considered as eligible Expense under this policy.

**Health Care Provider** means a health care facility or any other provider listed in Parts G and I, established and licensed as such by the State of Iowa.

**Hospital** means any of the following places: (a) a place licensed or recognized as a general hospital by the proper authority of the state in which it is located; (b) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; or (c) a place certified as a hospital by Medicare. Not included is a hospital or institution or a part of a hospital or institution which is licensed or used principally as a clinic, continued care or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

**Hospice Care Program** means a program for meeting the special needs of Terminally Ill individuals and their immediate families, by providing support and care during the illness and bereavement:

- (a) to individuals who have no reasonable prospect of cure and, as estimated by a Physician, have a life expectancy of less than six months; and
- (b) to the immediate families of those individuals.

**Injuries** means accidental bodily injuries received while Your policy is in force. They must result in loss independently of Sickness and other causes.

**Insured Person** means You or Your dependents who are insured under this policy.

**Medicaid** means the federal-state assistance program established under Title XIX of the federal Social Security Act.

**Medically Necessary** service or supply means one which:

- (a) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice;
- (b) is not considered experimental; and
- (c) could not have been omitted without adversely affecting the Insured Person's condition or the quality of medical care.

**Medicare** means the federal government health insurance program established under Title XVIII of the federal Social Security Act.

**Normal Childbirth** or **Normal Pregnancy** means childbirth or pregnancy free of complications.

**Nursing Facility** means a facility:

- (a) operated pursuant to law;
- (b) approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
- (c) primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a duly licensed physician;
- (d) that provides continuous twenty-four hour a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- (e) that maintains a daily medical record of each patient.

**Other Provider** means a provider of covered services who is not participating in Our Preferred PPO (Preferred Provider Organization) program.

**Our, We, or Us** means the Iowa Comprehensive Health Association.

**Outpatient Treatment Program** means counseling and therapy given in or through a Hospital, an Alcoholism Treatment center or an outpatient program certified to give the care. The Treatment must:

- (a) be upon the referral of a Physician; or
- (b) require the services of a Physician or psychotherapist.

**Physician** means a person, other than You or a member of Your immediate family, duly licenses and legally qualified to diagnose and treat Injuries and Sickness. He or she must be providing services within the scope of his or her license.

**Preferred Provider** means a provider of covered services who is participating in Our Preferred PPO (Preferred Provider Organization) program.

**Reconstruction** means any initial and subsequent reconstructive surgeries or prosthetic devices, and follow-up care determined necessary by the Physician.

**Sickness** means a sickness, disease or condition(s) which:

- (a) causes loss beginning while this policy is in force; or
- (b) is not excluded under a pre-existing condition limitation.

**Skilled Nursing Care** means any Treatment that is rehabilitative in nature, is required to restore an individual to his or her prior level of health after an accident or illness and hospitalization, and is related to the condition which was the cause of the Confinement. Skilled nursing care is any level of care greater than Custodial Care.

**Subrogation** means Our right to recover any policy payments: (a) made because of an Injury to You caused by a third party's wrongful act or negligence; and (b) which You later recover from the third party or the third party's insurer.

**Symmetrical Appearance** means that, in addition to prosthetic devices and reconstructive surgery for the diseased breast that the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the Physician, this surgery is necessary to achieve normal Symmetrical Appearance.

**Terminally Ill** means determined by a Physician to have no reasonable prospect of cure and to have less than six months to live.

**Third Party** means another person or organization.

**Transplant Surgery** means the insertion, by means of surgical operation, of an internal body organ from a live donor into the body of an individual.

**Urgent Care Center** means a free-standing facility offering ambulatory medical services which:

- (a) is not part of a Hospital; and
- (b) is licensed by the proper authority in the jurisdiction in which it is located.

**Utilization and Case Management Review Panel** (referred to as Panel throughout the policy). Area responsible for approving inpatient care or alternative treatment settings, and arranging or advising necessity for second surgical opinions. Call: [1- 866-295-1779]. Preadmission review is required when You or any Insured Person

(a) is confined as a resident patient in a hospital, (b) is confined as a resident patient in a Nursing Facility, (c) receives Outpatient Physical Rehabilitation benefits, or (d) receives Chiropractic Care.

**You or Your** means the person named as the Insured on the Policy Schedule.

## **PART G.**

### **BENEFITS**

(unless otherwise specifically listed or limited)

When you incur Expense for a covered Injury or Sickness, We will pay the Specified Percentage shown on the Schedule of such Expense that is in excess of the Deductible until the Out-of-Pocket Expense Maximum is reached (unless stated otherwise). Benefits are limited to: (a) the Lifetime Maximum Benefit (shown on the policy Schedule); and (b) Expense incurred in excess of the Calendar Year Deductible.

**NOTE:** Benefits payable for certain services and procedures may be less than listed in this section. Please review the Cost Containment Provisions for a further explanation.

**PREFERRED PROVIDER ORGANIZATION REQUIREMENTS.** You may choose any Physician, Hospital or other health care provider you wish. However, You are subject to the Other Provider Specified Percentage (shown in the Schedule), Other Provider Deductible (shown in the Schedule) and Other Provider Out-of-Pocket Maximum if You use the services of an Other Provider rather than a Preferred Provider. Regardless of the provider You choose, benefits will be subject to all other terms, conditions and limitations of the policy.

Preferred Providers are periodically added or deleted from the program. It is Your responsibility to ask Your providers if they are still participating in the Preferred Provider program prior to receiving Treatment. If Your Preferred Provider refers You to a specialist, You should determine if the specialist is also a Preferred Provider in order to receive maximum benefits.

The Iowa Comprehensive Health Association does not supervise, control or guarantee the health care services of any provider, including those participating in the Preferred Provider program.

**ASSIGNMENT OF BENEFITS.** Benefits payable for the services of a Preferred Provider must be assigned by You to such provider. Benefits will be paid directly to the Preferred Provider. Benefits payable for the services of an Other Provider which You have assigned will be paid to the provider of the services. If You have not assigned the benefits, We, at Our option, will pay You or the provider of the services.

**DEDUCTIBLE.** Deductibles mean the initial amount of Expense an Insured Person must incur each Calendar Year before benefits can be provided. Your Preferred Provider Deductible and Other Provider Deductible are shown on the Schedule and must be satisfied each Calendar Year. Subject to Policy provisions, only Expenses covered by Parts G and I will be used to satisfy the Deductibles. If you use the services of a Preferred Provider, the Preferred Provider Deductible will apply and if You use the services of an Other Provider, the Other Provider Deductible will apply.

Expenses used to satisfy the Deductibles in the last three months of a Calendar Year will be used toward satisfying the Deductibles for the next Calendar Year.

**SPECIFIED PERCENTAGE.** The Specified Percentage is the percentage of Expenses We will pay for covered services and supplies after Your Deductible has been satisfied in a Calendar Year. Specified Percentage means the Preferred Provider Specified Percentage or the Other Provider Specified Percentage. The Preferred Provider Percentage (as shown in the Schedule) applies when You use the services of a Preferred Provider and the Other Provider Specified Percentage (as shown in the Schedule) applies when You use the services of an Other Provider.

**COINSURANCE PERCENTAGE.** The Coinsurance Percentage is the percentage of Expenses You will pay for covered services and supplies after Your Deductible has been satisfied in a Calendar Year. The Preferred Provider Coinsurance Percentage (as shown in the Schedule) applies when You use the services of a Preferred Provider and the Other Provider Coinsurance Percentage (as shown in the Schedule) applies when You use the services of an Other Provider. You are responsible for the amount of this Coinsurance Percentage until the Stop Loss Limit has been met. The Stop Loss Limit is the amount of Expense incurred in a Calendar Year which is subject to the Coinsurance Percentage.

**COPAYMENT.** The Copayment is the amount payable at the time covered services are received.

The Coinsurance Percentages, Copayment, and Stop Loss Limit are shown in the Schedule.

**OUT-OF-POCKET MAXIMUM.** Out-of-Pocket Maximum means the Preferred Provider Out-of-Pocket Maximum (as shown in the Schedule) or the Other Provider Out-of-Pocket Maximum (as shown in the Schedule). The Preferred Provider Out-of-Pocket Maximum applies when You use the services of a Preferred Provider and the Other Provider Out-of-Pocket Maximum applies when You use the services of an Other Provider.

The Out-of-Pocket Maximum is the Stop Loss Limit multiplied by the Coinsurance Percentage plus the Deductible. That portion of the Expense covered under the Benefits provision, but not paid in full, will apply to this amount unless stated otherwise.

After You have paid the Out-of-Pocket Maximum, We will pay 100% of any additional covered Expense incurred in the same Calendar Year. This 100% will apply unless stated otherwise.

The Out-of-Pocket Maximum is shown on the Schedule. That portion of the Expense covered under the Benefits provision, but not paid in full, will apply to this amount unless stated otherwise.

Any Expense in excess of the Calendar Year Maximum will NOT be considered Covered Services and Supplies. Therefore, those Expenses will NOT be applied to the Out-of-Pocket Maximum.

**NOTE:** Benefits payable may be less than listed in this Part G. Please review Part I, Cost Containment Provisions, for a further explanation.

## **COVERED SERVICES AND SUPPLIES**

### **Inpatient Medical/Surgical Services**

1. Inpatient Hospital Confinement - Hospital room and board and any other hospital-furnished medical services and supplies, including inpatient drugs and prescriptions requiring a Physician's written prescription, when confined to the hospital as an inpatient. For hospital room and board charges, only the following will be considered:
  - (a) the most common semi-private room charge;
  - (b) the most common private room if semiprivate rooms do not exist in the health care facility; or
  - (c) the private room charge if Medically Necessary.
2. Inpatient Physician and Professional Services – Inpatient Physician and Professional services for the diagnosis or treatment of Injuries or Sickness, other than mental, which are rendered by a Health Care Provider or at the direction of a Health Care Provider.
3. Inpatient Physical Rehabilitation Services – Short-term physical rehabilitation physician and professional services and supplies, including but not limited to physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation.

4. Nursing Facility – Only the first 60 days of Confinement in a Nursing Facility will be considered as Expense in a Calendar Year. Charges in excess of the most common semi-private room charge will not be considered covered Expense.

Expense incurred after the 60th day of Confinement in such facility in a Calendar Year will not be used toward satisfying the Out-of-Pocket Expense Amount or Deductible.

Confinement in a hospital will be considered as a covered service or supply if:

- (a) the level of care needed has been reclassified from acute care to Skilled Nursing Care; and
- (b) no Skilled Nursing Care beds are available within a 30-mile radius of the hospital.

### **Outpatient Medical/Surgical Charges**

1. Ambulatory Surgical Center charges.
2. Emergency room covered services and supplies are subject to a \$100.00 Copayment amount. The Emergency room Copayment amount will be waived in the event of a Hospital Confinement admission.
3. Urgent Care Facility covered services and supplies are subject to a \$100.00 Copayment amount.
4. Outpatient Professional and Physician Services – Outpatient Professional services and supplies for the diagnosis or treatment of Injuries or Sickness, other than mental, which are rendered by a Health Care Provider or at the direction of a Health Care Provider are subject to the following:
  - (a) Charges for Preferred Provider office visits are subject to the Physician Office Copayment Amount shown in the Policy Schedule. All other charges for services or supplies received by a Preferred Provider are subject to the Deductible and Coinsurance shown in the Policy Schedule.
  - (b) Covered Expenses for services and supplies received from an Other Provider are subject to the Deductible and Coinsurance shown in the Policy Schedule.
5. Outpatient Physical Rehabilitation Services - Physical rehabilitation professional services and supplies, including but not limited to physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation are covered Expenses subject to:
  - (a) case management review by the Panel and Part I, Cost Containment Provisions;
  - (b) the first 15 visits in a Calendar Year, and
  - (c) the Deductible and Coinsurance.
6. Outpatient Contraceptive Services – Benefits are payable for outpatient contraceptive services, including prescription drugs and devices requiring a Physician's written prescription. Outpatient contraceptive prescriptions are subject to Part H including the Outpatient Prescription Drug Copayments Amounts as shown in the Policy Schedule.

### **Other Covered Services**

1. Use of radium or other radioactive material.
2. Oxygen.
3. Anesthetic and its administration.
4. Benefits are payable for the processing of blood, including but not limited to, collecting, testing, fractioning and distributing blood.
5. Medical supplies:
  - (a) artificial eyes or prosthetic limbs;
  - (b) surgical dressings, casts, splints, trusses, braces, crutches or heart pacemakers;
  - (c) rental or (at Our option) purchase of a wheelchair or hospital-type bed or other Medically Necessary Durable Medical Equipment; and
  - (d) rental or (at Our option) purchase of mechanical equipment required for respiratory paralysis.

Expenses for Durable Medical Equipment are subject to prior approval by Us.

6. Diagnostic x-rays and laboratory examinations.
7. Chiropractic Care - Benefits are payable for Chiropractic Care services and supplies subject to rehabilitation limits and the Cost Containment Provisions, Part I.
8. Oral surgery for any of the following services:
  - (a) excision of partially or completely unerupted impacted teeth;
  - (b) excision of a tooth root without extraction of the entire tooth;
  - (c) disease of the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
9. Emergency Care & Services - If You receive Emergency Services and cannot reasonably reach a Preferred Provider, Emergency Services received during the course of the emergency will be payable as though You had been treated by a Preferred Provider.
  - (a) Benefits for Professional ambulance service to the nearest health care facility qualified to treat the Injury or Sickness are covered expenses.
  - (b) Benefits for Air ambulance service to or from a hospital are covered expenses. Such service must be:
    - (i) needed because of a critical Sickness or Injury that requires special medical treatment not available in the immediate area;
    - (ii) ordered by a Physician; and
    - (iii) in an aircraft used primarily for transporting sick or injured persons.
10. Hospice Care – Hospice care must be provided by a hospital-related institution, home health agency, hospice or other licensed facility which would be approved under Medicare or any applicable state law as a Hospice Care Program. To be considered as Covered Services, such services must be a part of a Hospice Care Program for:
  - (a) inpatient care services;
  - (b) Physician services; or
  - (c) home hospice care services.

Benefits for the above are limited as follows:

- (a) benefits are payable only if the Terminally Ill person is the Insured Person;
- (b) counseling (other than bereavement counseling) for the Insured Person's immediate family not to exceed a total of 90 visits per family (the immediate family includes the Insured Person's spouse, children and parents); and
- (c) bereavement counseling for the Insured Person's immediate family not to exceed a total maximum benefit of \$250.00.

Charges in excess of those that produce the above maximums will not be used in satisfying the Deductible or the maximum Out-of-Pocket Expense Amount.

11. Home Health Care - We will pay expenses for 40 home health care visits incurred in a Calendar Year. Benefits for home health care are payable only if such care is:
  - (a) received in lieu of hospitalization;
  - (b) furnished under a planned program by an agency licensed to provide home health care; and
  - (c) ordered and directed by Your Physician.
12. Inpatient or Outpatient Mental or Nervous Disease and Alcoholism and Drug Addiction Treatment - Benefits are payable for Expenses incurred when received from a Preferred Provider on either an inpatient or outpatient basis for Mental or Nervous Disease and Alcoholism and Drug Addiction Treatment subject to the following:
  - (a) only the first 20 days of inpatient Treatment for either Mental or Nervous Disease or Alcoholism or Drug Addiction will be considered a covered eligible Expense in a Calendar Year;
  - (b) only the first 45 visits of outpatient Treatment for either Mental Health or Alcoholism or Drug Addiction will be considered a covered eligible Expense in a Calendar Year; and
  - (c) benefits are combined benefits and subject to the Deductible, Coinsurance, all policy provisions.

**Alcoholism or Drug Addiction** means an illness characterized by:

- (a) a physical and/or psychological dependency on alcohol or controlled substances; or
- (b) habitual lack of self-control in using alcohol or controlled substances to the extent that the Insured Person's health is substantially impaired, or social or economic function is substantially disrupted.

**Mental or Nervous Disease** means any mental or emotional condition, disease, or disorder, regardless of cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder.

**Outpatient Facility** means a facility providing nonEmergency Services other than an Independent Radiology and Pathology Center, Urgent Care Center or Hospital Emergency Room.

**Treatment** means an inpatient or Outpatient Treatment Program, including but not limited to:

- (a) detoxification;
- (b) medical or psychiatric evaluation;
- (c) family therapy;
- (d) counseling; and
- (e) prescription drugs, as provided for in Parts G and H, and supplies.

13. Diabetes - We will pay the Expense incurred for equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a Physician.

Coverage will include Expenses for:

- (a) blood glucose meter and glucose strips for home monitoring; and
- (b) diabetes self-management training and education.

Payment for diabetes self-management training and education will only be covered under all of the following conditions:

- (a) Physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition;
- (b) the diabetic self-management training and education program is certified by the Iowa Department of Public Health;
- (c) initial training will cover up to ten hours of initial outpatient diabetes self-management training with a continuous twelve-month period for each individual;
- (d) an individual who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

Benefits for diabetes self-management training and education are not subject to the Deductible. Benefits for diabetes self-management training and education are subject to the Coinsurance amount.

14. Breast Reconstruction After Mastectomy Surgery - If an Insured Person receives benefits in connection with a mastectomy, We will provide coverage for:

- (a) Reconstruction of the breast on which the mastectomy has been performed.
- (b) Surgery and Reconstruction of the other breast to produce a Symmetrical Appearance.
- (c) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

15. Temporomandibular Joint Dysfunction (TMJ) - We will provide benefits for Expenses incurred for temporomandibular joint dysfunction subject to a \$1,000.00 lifetime maximum and except for: crowns which correct vertical dimension; splints, orthopedic repositioning appliances, biteplates and equilibration treatments (including splint equilibration and adjustments); bite, functional or occlusal registration, with or without splints, and kinesiographic analysis; any orthodontic treatment, including extraction of teeth; study models, except for the complete model made necessary when surgical intervention is completed. Surgical charges for correction of orthognathic conditions are covered subject to the lifetime maximum.

16. Transplant Surgery Benefit - If You receive an organ transplant from a Center of Excellence that is certified by the Panel as Medically Necessary, benefits will be payable for Covered Services and Supplies at the Preferred Provider normal percentage rate after the Deductible. If the transplant surgery is not certified by the Panel as Medically Necessary or is determined to be investigative or experimental, no benefits will be payable for such procedure or other Covered Services and Supplies.

If You or a dependent has transplant surgery for which surgical benefits are payable under this policy, and if the Donor requires surgery to make an organ available, any Expense incurred by the Donor for charges made by a Physician for surgery will be included as Expense incurred by You or a dependent.

If You or a dependent has transplant surgery for which medical benefits are payable under this policy, and if the Donor

requires surgery to make an organ available, any Expense incurred by the Donor for charges made by a Physician for Physician visits needed because of such operation will be included as Expense incurred by You or a dependent.

The benefits noted above are subject to the following limitation:

Benefits for the Donor will be provided to the same extent that they remain and are available under this policy. Benefits for the Donor are payable only after expense has been paid for the Insured Person.

#### **Preventative Care**

1. Well Child Care - Expenses incurred for well child care will be considered a covered Expense if provided by a Preferred Provider. Well Child Care means care provided at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months or 2 years, 3 years, 4 years, 5 years, and 6 years. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.
2. Lead Screening - Expenses incurred at ages birth through seven years for the screening for lead exposure as well as blood levels will be considered a covered Expense if provided by a Preferred Provider. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.
3. Adult Physical Examinations - Expenses incurred for annual routine adult physical examinations will be considered a covered Expense if provided by a Preferred Provider. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.
4. Routine Mammography - Expenses incurred for annual routine mammography for an Insured Person age 35 years or older, or if more frequently if advised by the Insured Person's Physician, will be considered a covered Expense if provided by a Preferred Provider. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.
5. Routine Pelvic Exam and Pap Test - Expenses incurred for an annual routine, or upon referral of a Physician, pelvic exam and pap test for insured female ages 18 to 64 years of age will be considered a covered Expense if provided by a Preferred Provider. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.
6. Prostate Specific Antigen Tests - Expenses incurred for annual medically recognized diagnostic prostate cancer screening examination for an insured male age 40 years or older will be considered a covered Expense if provided by a Preferred Provider. Benefits include, but are not limited to, a digital rectal examination and a prostate-specific antigen (PSA) test. Expenses are not subject to the Deductible. Expenses are subject to the Coinsurance and the Out-of-Pocket Maximum shown in the Policy Schedule. No benefits will be payable in the event services or supplies are received by an Other Provider.

All charges for those services and supplies not covered will not be used toward satisfying the Deductible or Out-of-Pocket Expense Amount or be considered covered Expense.

#### **PART H. OUTPATIENT PRESCRIPTION DRUG BENEFITS**

PAYMENT FOR A PRESCRIPTION DRUG DOES NOT CONSTITUTE ANY ASSUMPTION OF LIABILITY FOR SICKNESS, INJURY, OR CONDITION UNDER THIS POLICY.

##### **Definitions**

For the purposes of this Outpatient Prescription Drugs Benefit provision, the following terms have the following meanings:

**Brand Name Drugs** means proprietary Covered Drugs approved by the Federal Food and Drug Administration (FDA).

**Brand Name Drug Copayment** means the amount shown on the Schedule which is the amount that is not payable by Us and must be paid by You directly to the pharmacy for Brand Name Drugs.

**Drug Copayment** means an amount which the Insured Person must pay before benefits are payable and which is incurred on the date the Covered Drug is received. An Outpatient Prescription Drug Copayment can be a dollar amount, a percentage amount, or a combination of a dollar amount and a percentage. Outpatient Prescription Drug Copayments may not be used to satisfy any Deductible or any stop-loss limit shown in any other provision of the policy. However, the Outpatient Prescription Drug Copayment will be used to satisfy any Prescription Drug Stop-Loss Limit shown in this provision. If the cost of the prescription is less than what the computed copayment would be, the copayment amount is the cost of the prescription.

**Covered Drugs** means either of the following which require a Physician's written prescription:

- (a) drugs and medicines which are needed for the treatment of an Injury or Sickness, including insulin and certain Diabetic Supplies; or
- (b) contraceptives.

**Diabetic Supply** or **Diabetic Supplies** include needles, syringes, test tablets, sticks, tapes, strips and lancets. All other covered diabetic benefits will be paid under the Benefits provision, Part G.

**Drug Formulary** means Our current listing of Covered Drugs preferred by Us for dispensing to an Insured Person when appropriate. This list is subject to periodic review and modification. In the event a Covered Drug is no longer on the Drug Formulary, We will send a notice to the Insured Person who is currently using such drug. The notice will be sent 30 days before the drug is removed from the Drug Formulary.

**Emergency Care** means those Covered Drugs provided in cases of life threatening, disabling or serious Injury or Sickness, including severe pain, which arises or worsens suddenly and which, if not treated immediately, could result in loss of life or permanent damage to a person's health.

**Generic Prescription Drugs** means Covered Drugs which are chemically equivalent to Brand Name Drugs whose patent has expired and which are approved by the Federal Food and Drug Administration (FDA). Not all Brand Name Drugs have a generic equivalent.

**Generic Prescription Drug Copayment** means the amount shown on the Schedule, that is not payable by Us and must be paid by You directly to the pharmacy for generic drugs.

**Medically Necessary**, as used in this provision, means prescription drug products which are:

- (a) determined to be medically appropriate;
- (b) dispensed pursuant to a prescription order or refill;
- (c) necessary to meet the basic health needs the Insured Person; and
- (d) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.

The fact that a prescribing Physician prescribes a Covered Drug or the fact that it may be the only treatment for a particular Injury or Sickness does not mean that it is Medically Necessary.

**Non-Participating Pharmacy** means a retail or mail-order pharmacy that is not under contract with the Prescription Service Card Administrator to fill a prescription order.

**Participating Pharmacy** means a local retail pharmacy or mail-order pharmacy that is under contract with the Prescription Service Card Administrator to fill a prescription order with when a Prescription Service Identification Card is presented. We do not supervise, control or guarantee the services of any Participating Pharmacy or Non-Participating Pharmacy.

**Preferred Brand Name Drug** means Brand Name Drugs that are listed as "Preferred" on a listing maintained by or on behalf of Us. Currently that listing is located at [[www.prescriptionnetwork.info](http://www.prescriptionnetwork.info)]. We may change the location of the Preferred Brand Name Drug listing from time to time by notice(s) at [[www.HIPIOWA.COM](http://www.HIPIOWA.COM)].

**Preferred Brand Name Drug Copayment** means the amount shown on the Schedule that is the amount that is not payable by Us and must be paid by You directly to the pharmacy for Preferred Brand Name Drugs.

**Prescription Drug** means any medication or medicinal substance which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Drug order.

**Prescription Service Card Administrator** means the firm contracted to administer the Prescription Drug benefit.

**Prescription Service Identification Card** means the card provided by Us that must be shown when You have a prescription order filled at a Participating Pharmacy.

**Therapeutically Equivalent Drug** means a drug product that contains a different chemical entity, but provides similar treatment effects or pharmacological action.

### **Benefits**

This benefit applies to drugs (including contraceptive drugs) and medicines dispensed by a licensed Participating Pharmacist that require a prescription, and are purchased upon a Physician's orders using Your Prescription Service Identification Card but not obtained through the following facilities while the Insured Person is confined in a:

- (a) Hospital;
- (b) Nursing Facility or convalescent home;
- (c) rest home or nursing home; or
- (d) sanitarium or Treatment Facility.

Benefits are subject to the Prescription Drug Copayment Amounts listed in the Schedule. If You purchase Generic Prescription Drugs, You will be required to pay the Generic Prescription Drug Copayment amount listed in Your Schedule. If You purchase a Preferred Brand Name Drug, Your benefits are subject to the Preferred Brand Name Drug Copayment amount listed in the Schedule. If You purchase Brand Name Drugs, Your benefits are subject to the Brand Name Drug Copayment amount listed in the Schedule. When available, Your prescription will be filled with a Generic Prescription Drug. If You choose to purchase a Brand Name Drug when a generic equivalent is available, You will pay the Brand Name Prescription Drug Copayment plus the difference in cost between the Brand Name Drug and Generic Prescription Drug. If there is no FDA-approved, chemically-equivalent Generic Drug, We will pay the total Expense for the Brand Name Drug after the Prescription Copayment is satisfied.

After the Insured Person pays the Prescription Drug Copayment amount shown in the Schedule, We will pay the remaining Expense incurred for a Covered Drug obtained from a Participating Pharmacy for up to:

- (a) a 30-day supply from a retail Participating Pharmacy; or
- (b) a 90 day supply from a mail order Participating Pharmacy.

You pay one copayment for each prescription filled (or refilled) up to a 30-day supply from a retail Participating Pharmacy. Any single fill (or refill) exceeding the 30-day limit requires additional copayments.

You may order up to a 90-day supply of mail order Prescription Drugs. Any prescription filled by mail order will have twice the copayment amount listed in the Schedule applicable to that drug.

Prescription Drug Copayment amounts do not apply to the policy Deductible or the Out-of-Pocket Maximum Amounts.

**OPEN FORMULARY:** You are not restricted to the listed medications under the Drug Formulary. We encourage You to discuss Your medication needs with Your Physician. Your Physician may be contacted to discuss Your prescriptions that are included on the Drug Formulary as well as those that are not included on the Drug Formulary.

**PRESCRIPTION DRUG STOP-LOSS LIMIT:** After each Insured Person reaches the Calendar Year Out-of-Pocket Maximum Prescription Drug Limit shown in the Policy Schedule, We pay 100% of the Expense incurred for Prescription Drugs when obtained through a Participating Pharmacy for the remainder of a Calendar Year.

### **Exceptions and Limitations**

Drugs and medicines received while being treated as a Hospital inpatient will not be subject to this benefit provision.

You must pay 100% of the prescription order at the time You place the prescription order if:

- (a) You do not show Your Prescription Service Identification Card at the Participating Pharmacy; or
- (b) You use a Non-Participating Pharmacy to fill the prescription order.

Benefits for Emergency Care by a Non-Participating Pharmacy will be paid in the same manner as if the services were by a Participating Pharmacy.

You may be reimbursed for eligible expenses if You submit a claim to the Prescription Service Card Administrator on a form available from us. The Prescription Service Card Administrator will pay the eligible expenses incurred based on the amount that would have been paid to a Participating Pharmacy subject to the copayment amounts.

With the prescribing Physician's approval, We may, at Our discretion, substitute:

- (a) one Brand Name Drug for another Brand Name Drug; or
- (b) one Therapeutically Equivalent Drug for another Therapeutically Equivalent Drug.

Certain drugs do require prior authorization by Us to be covered, or may be subject to clinical quantity limits. We may use other clinical management programs to ensure appropriate medication utilization.

Prescription refills will be covered when no more than 25% of the days' supply remains based on the Physician's written order. If the Insured Person is purchasing more than a 30-day supply from a retail Participating Pharmacy or a 90 day supply from a mail order Participating Pharmacy, any Expense exceeding the 30-day or the 90 day supply limit will not be covered by Us.

Any prescription exceeding \$1,000 in cost (per claim) must be reviewed and approved for payment.

This Outpatient Prescription Drug Benefit does not pay for:

- (a) drugs or medicines dispensed more than (12) months after the date of the prescription;
- (b) therapeutic appliances, devices or garments including, but not limited to, hypodermic needles and syringes (insulin syringes for diabetic use are covered), colostomy supplies, support hose and other non-medicinal substances, regardless of use;
- (c) drugs for which a provider's usual and customary charges are either equal to or less than the copayment amount;
- (d) medication for which the costs is recoverable under any worker's compensation or occupational disease law or any State or Government Agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- (e) any drug labeled, "Caution - Limited by Federal Law to Investigational Use," or experimental or other drugs which are prescribed for unapproved uses;
- (f) drugs or medicines that have been determined under the internal standards of the Federal Food and Drug Administration (FDA) to be "less-than-effective" in accordance with the Drug Efficacy Study Implementation (DESI) or where the same prescription drug item, or an equivalent, is also available over-the-counter (OTC) or can lawfully be obtained without a Physician's prescription;
- (g) any charge for the administration of any drug;
- (h) medication which is to be taken or administered to the Insured Person, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, Treatment Facility, or similar institution;
- (i) drugs charges exceeding the costs for the same drug in conventional packaging (e.g., unit dose);
- (j) drugs administered by a physician;
- (k) drugs available in a equivalent does over-the-counter which doe not require a prescription order by federal or state law (insulin and diabetic supplies are covered);
- (l) any medication related to injuries resulting from a motor vehicle accident to the extent that such services are payable under any automobile insurance policy;
- (m) immunization agents, antigens, allergy and biological sera, blood or blood plasma, parenterals, radioligicals (except as provided under Part G, Benefits, Preventative Care provisions);
- (n) any medication refilled before 75% of the previous fills' days supply has expired;
- (o) drugs that have no FDA-approved indications for use;
- (p) FDA-approved drugs or dosage regimens used for indications or routes of administration outside FDA-approval;
- (q) dietary supplements;
- (r) drugs or medicines used for cosmetic purposes or beauty aids;
- (s) injectable drugs and medicines (except for Medically Necessary, self-administered drugs and medicines, such as insulin);
- (t) drugs or medicines obtained through a Non-Participating Pharmacy;
- (u) Expense for which benefits are paid under any other provision of the policy; or
- (v) anything excluded under the Exceptions and Limitations, Part J.

DRUG COMPANY REBATES: Drug manufactures offer rebates to pharmacy benefit managers such as the one We use. We expect to receive a share of these rebates. Any rebates will be received and retained by Us to help lower Our cost of operations. The rebates will not be allocated to an Insured Person's specific claim nor will they be considered when determining an Insured Person's payment obligation.

## **PART I. COST CONTAINMENT PROVISIONS**

The following are provisions designed to reduce the total cost of medical care received by the Insured Person because of a covered Injury or Sickness. Benefits which are payable and subject to these cost containment provision will apply toward the Lifetime Maximum Benefit shown in the Policy Schedule and explained in Part G, Benefits. Your portion of covered Expense for any item under these Cost Containment Provisions will apply toward the Out-of-Pocket Expense Amount explained in Part G, Benefits, unless stated otherwise. The Deductible stated in Part G, Benefits, will also apply unless stated otherwise. Expense covered by Parts G and this Part I will be used to satisfy the Deductible unless stated otherwise.

**HOSPITAL CONFINEMENT, NURSING CARE CONFINEMENT, OUTPATIENT PHYSICAL REHABILITATION, AND CHIROPRACTIC CARE PRECERTIFICATION AUTHORIZATION REVIEW REQUIREMENTS:** Precertification review is required when as Insured Person is or is about to:

- (a) be hospital confined;
- (b) receive Nursing Care Confinement;
- (c) receive Outpatient Physical Rehabilitation benefits; or
- (c) receive Chiropractic Care.

**RULES FOR HOSPITAL CONFINEMENT, NURSING CARE CONFINEMENT, OUTPATIENT PHYSICAL REHABILITATION, AND CHIROPRACTIC CARE PRECERTIFICATION REVIEW:**

- (a) **For a Non Emergency Admission** – The attending Physician must notify and give Admission Information, Outpatient Physical Rehabilitation treatment information, or Chiropractic Care information to the Utilization Review Panel by telephone before the admission, receipt of Outpatient Physical Rehabilitation, or the receipt of Chiropractic Care services. Within one day after the Panel receives the required information, the Panel will send written notice of any one period of Confinement, Outpatient Physical Rehabilitation, or Chiropractic Care services which is certified as Medically Necessary to:
  - (1) You;
  - (2) the Physician; and
  - (3) the hospital or Care Facility.

Admission Information includes the following information that the attending Physician must provide to the Panel before a period of Confinement is approved:

- (a) the diagnosis or reason for the Confinement;
- (b) any proposed Treatment or surgical procedure; and
- (c) the expected days of Confinement.

If the Panel does not receive the notice before admission or the receipt of Outpatient Physical Rehabilitation or Chiropractic Care services, coverage will be provided as explained in the Effect on Benefits provision.

- (b) **For an Emergency Admission** – If the Insured Person is confined for treatment of an injury or as a result of a medical emergency, then the attending Physician must notify and give admission information to the Panel by telephone:
  - (1) within 48 hours after a weekday admission;
  - (2) within 72 hours after a weekend admission; or
  - (3) as soon as reasonably possible after that.

On the same business day that the Panel receives the required information, the Panel will:

- (1) telephone the Physician and confirm any days of inpatient Confinement which are certified as Medically Necessary; and
- (2) send written notice to You, the Physician and the facility of any Confinement to confirm any days of Confinement which are certified as Medically Necessary.

- (c) **For Continued Confinement** – Before the approved period of Confinement ends, the Panel will contact the attending Physician to determine whether the Insured Person requires further inpatient Confinement. On the same business day, You, the Physician, and the Hospital will be sent written notice to confirm any additional

days of Confinement which are certified as Medically Necessary.

**EFFECT ON BENEFITS:** For expense incurred for days of Confinement, Outpatient Physical Rehabilitation services, or Chiropractic Care services which are certified by the Panel as Medically Necessary, benefits will be payable as stated in Part G, Benefits. For expense incurred for days of inpatient Confinement, Outpatient Physical Rehabilitation, or Chiropractic services which are not certified as Medically Necessary, no benefits will be payable. Benefits for non-emergency Outpatient Physical Rehabilitation, Inpatient Confinement or Nursing Care Confinement will be reduced by \$1,000.00 if the Insured Person receives retroactive precertification review. This \$1,000.00 will not be applied toward satisfying the Deductible or be considered covered expense. Expense incurred during days of Confinement which are not certified by the Panel as Medically Necessary will not be used to satisfy the maximum Out-of-Pocket Expense Amount.

**HOSPITAL PREADMISSION TESTING BENEFIT:** When the Insured Person incurs Expense for hospital preadmission testing, We will pay 100% of such Expense subject to the limitations outlined below. The Deductible does not apply.

Benefits will be payable only if:

- (a) the Insured Person's Physician determines before the tests are performed that hospital Confinement is required; and
- (b) the tests are performed:
  - (1) on an outpatient basis;
  - (2) within seven days of admission as a resident patient; and
  - (3) in connection with a covered hospital Confinement.

**MANDATORY SECOND SURGICAL OPINION BENEFIT:** A second surgical opinion is mandatory when any surgical procedure listed below is to be performed on an inpatient basis. If the second opinion does not confirm the need for surgery, a third opinion is required. The second or third opinion must confirm that surgery is Medically Necessary before benefits will be paid under Part G, Benefits. If the second or third opinion does not confirm that surgery is Medically Necessary, then no benefits are payable.

We will pay 100% of the Expense incurred for a second or third opinion on the need for surgery (including x-ray and laboratory services). The Deductible will not apply.

Conditions: Benefits will be payable only if:

- (a) the opinion is given by a specialist who:
  - (1) is certified by the American Board of Medical Specialties in a field related to the proposed surgery;
  - (2) is independent of the Physician who first advised the surgery; and
  - (3) does not perform the surgery for the Insured Person.
- (b) the specialist makes a personal exam of the Insured Person; and
- (c) the specialist sends Us a written report.

**SURGICAL PROCEDURES FOR WHICH A SECOND SURGICAL OPINION IS MANDATORY:**

- (a) breast surgery, augmentation or reduction
- (b) bunionectomy (foot surgery)
- (c) cholecystectomy (removal of gallbladder)
- (d) coronary artery bypass surgery
- (e) hemorrhoidectomy, internal or external
- (f) hernia repair, inguinal or hiatal
- (g) hysterectomy (removal of uterus)
- (h) laminectomy (back surgery)
- (i) ligation and/or stripping of varicose veins in legs
- (j) meniscectomy (knee surgery)
- (k) septoplasty and/or submucous resection (nose surgery)
- (l) tonsillectomy and/or adenoidectomy (removal of tonsils or adenoids)
- (m) transurethral prostatectomy (removal of prostate)

## **PART J. EXCEPTIONS AND LIMITATIONS**

No benefits are payable for:

- (a) services rendered prior to the effective date of coverage under this policy for the person on whose behalf the Expense is incurred;

- (b) dental care, dental surgery, dental treatment or for dental appliances, except as provided in Part G, Benefits;
- (c) services or supplies provided by or paid for by the Veterans Administration, except for services rendered on an emergency basis where a legal liability exists for charges made for such services;
- (d) eye refractions, eyeglasses, contact lenses, hearing aids or their fitting;
- (e) routine vision and hearing exams, except those provided in Part G, Benefits, Preventative Services provisions;
- (f) refractive corneal surgery, except for corneal grafts;
- (g) allergy treatment and therapeutic allergy treatment, including allergy injections;
- (h) loss that results from an act of declared or undeclared war;
- (i) loss sustained while in an armed service (upon notice to Us of entry into a service, the pro rata premium will be refunded);
- (j) expenses for Normal Childbirth, Normal Pregnancy (unless You purchase the optional Maternity Benefit Rider) or voluntarily induced abortion;
- (k) gender transformations or changes or the promotion of fertility including (but not limited to):
  - (1) fertility tests;
  - (2) reversal of surgical sterilization; and
  - (3) direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization or embryo transfer;
- (l) expenses for any loss, expense or charge which results from appetite control, weight control or any treatment of obesity not caused by an organic condition;
- (m) expense for obesity not caused by sickness or injury;
- (n) expenses for custodial care, convalescent, rest, or nursing facility care expenses except as provided for in Part G, Benefits;
- (o) expense for routine treatment of feet including orthopedic shoes, foot inserts, or support devices;
- (p) expenses for smoking cessation;
- (q) expenses for biofeedback;
- (r) expenses for massage therapy;
- (s) expenses for treatment of behavior modification and learning disabilities,
- (t) expenses for alternative medicines;
- (u) suicide while sane or insane, or any attempt threat;
- (v) expense paid by Medicare or Medicaid;
- (w) investigative or experimental procedures, treatments, equipment, transplants or implants;
- (x) any expenses incurred that are covered by any local, state or federal programs;
- (y) loss that is covered by any other insurance or medical expense benefits plan;
- (z) growth therapy treatment;
- (aa) expense for breast augmentation or breast reduction in absence of malignancy;
- (bb) private duty nursing, except for covered Home Health Care or Hospice Care services, Part G, Benefits;
- (cc) expenses incurred for acupuncture, naturopathy, or homeopathy; and
- (dd) expenses incurred for services or treatment not Medically Necessary.

**COSMETIC OR RECONSTRUCTIVE SURGERY LIMITATIONS:** Benefits for cosmetic or reconstructive surgery are payable only if for or due to:

- (a) Injuries received while this policy is in force;
- (b) conditions that result from surgery for which benefits were paid under this policy;
- (c) repair of congenital defects of newborn children.

These limitations for cosmetic and reconstructive surgery do not apply to federally eligible individuals.

**DUPLICATION OF BENEFITS:** If a single item of Expense is payable under more than one provision of this policy, payment will be made only under the provision providing the greater benefit. This does not apply to Hospital Confinement, Nursing Care Confinement, Outpatient Physical Rehabilitation Review Requirements, Chiropractic Care services, Hospital Preadmission Testing, and Transplant benefits.

Benefits for Covered Services and Supplies are subject to the limitations and requirements described in Part G, Benefits, and Part I, Cost Containment Provisions, of this policy.

## **PART K.**

### **NONDUPLICATION OF BENEFITS**

**OTHER MEDICAL INSURANCE:** The amount of Other Medical Insurance is equal to the total amounts paid for Covered Services and Supplies provided by the following: (a) any other health insurance policy; (b) all Hospital and medical Expense benefits paid or payable under any workers' compensation coverage; (c) automobile medical payment or liability insurance whether provided on the basis of fault or nonfault; and (d) by any Hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

Other Medical Insurance includes the above plans regardless of whether provided on an individual, family or group basis through an employer, union, or membership in an association. If coverage is provided by a Blue Cross and Blue Shield Plan or any similar provision-of-service basis, the amount of benefit under such coverage shall be equal to the amount which the service rendered would have cost in the absence of such coverage.

Other Medical Insurance DOES NOT include any of the following:

- (a) any Hospital indemnity plan providing coverages on a nonexpense-incurred basis;
- (b) any cancer and/or specified disease plan; or
- (c) any accident only plan.

This plan is the last payor of benefits whenever any other benefit, including but not limited to Medicare, is available. Benefits otherwise payable under this policy shall be reduced by all amounts paid or payable, or reimbursed directly by or under any Other Medical Insurance, whether insured or otherwise. We will not pay benefits for a period in which Other Medical Insurance with an effective date prior to the effective date of this plan was in force.

Whenever the Administrator has allowed benefits to be paid by this plan which have been paid by any Other Medical Insurance, or which were erroneously paid, the Administrator will have the right to recover any such excess payments from the appropriate party.

## **PART L.**

### **SUBROGATION**

If there is Other Medical Insurance or if You are injured through the act or omission of a third party, and if benefits are paid under this policy due to the Injury, then to the extent any recovery by You:

- (a) against a third party is made; and
- (b) is attributable to the same Injury;

We shall be entitled to reimbursement for all such benefits paid by Us. We may file a lien for such payment. Upon request, You must complete and return to Us the required forms.

Our right of subrogation includes Your compliance with any or all of the following:

- (a) Make proper and timely applications for any and all Other Medical Insurance for which You may be eligible.
- (b) Furnish Us with proof of any such applications.
- (c) Provide Us written authorization to receive information about the status of Your applications.
- (d) Provide Us a copy of the award or other evidence of payment of Other Medical Insurance immediately upon receipt.
- (e) Submit written evidence that You have been denied Other Medical Insurance.
- (f) Pursue any established appeals process and provide Us with evidence of the decision or ruling.
- (g) If after the appeals process You are still denied Other Medical Insurance, We may require that You reapply for it from time to time and provide proof of the appeals.
- (h) Provide Us a copy of the retroactive award or other evidence immediately upon receipt.
- (i) Notify Us of any change in Your status as to Your eligibility for, entitlement to or receipt of any Other Medical Insurance. Such notice must be made within 30 days of Your status change.

## **PART M.**

### **DEPENDENTS PROVISIONS**

Each Insured Person must independently meet the eligibility requirements for coverage under this policy. However, Your children born while this policy is in force will be insured automatically from birth until:

- (a) the 31st day following birth; or
- (b) the first day of the second month following birth, whichever is longer.

Benefits are payable for medically diagnosed congenital defects and birth abnormalities during the period of automatic coverage; thereafter, only if Your newborn child meets the eligibility requirements on his or her own accord for coverage by

us.

## **PART N. HOW TO FILE A CLAIM**

**NOTICE OF CLAIMS.** You must give Us written notice of claim within 20 days after a loss occurs or starts, or as soon as You can. You may give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Policy Schedule. Notice should be mailed to us at the address on Your current identification card.

**CLAIM FORMS.** When We receive Your notice, We will send You forms for filing proof of loss. If We do not send them within 15 days, You can meet the proof of loss requirement by giving Us a written statement of what happened. We must receive this statement within the time given for filing proof of loss.

You must give Us written proof of Your loss within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

## **PART O. PAYMENT OF CLAIMS**

All benefits will be paid to You, Your assignees, Your beneficiary or Your estate as soon as We receive proof of loss and determine what benefits, if any, are payable.

If any benefits are payable to Your estate, to a minor or to any person not legally able to give a valid release, We may pay up to \$1,000.00 to any relative of Yours who We find entitled to the payment. Payment made in good faith shall fully discharge Us to the extent of the payment.

## **PART P. TERM OF COVERAGE**

Your coverage starts on the Policy Date at 12:01 a.m., Standard Time, where You live. It ends at 12:01 a.m., the same Standard Time, on the First Renewal Date. Each time You renew Your policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

## **PART Q. POLICY PROVISIONS**

**ENTIRE CONTRACT; CHANGES.** This policy, and any attachments, is the entire contract of insurance. Only the Board of Directors of the Iowa Comprehensive Health Association can approve a change. Any such change must be shown in Your policy.

**TIME LIMIT ON CERTAIN DEFENSES.** After two years from the date a person becomes covered under this policy, We cannot use misstatements, except fraudulent misstatements in Your application, to avoid coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after two years from the date a person becomes covered under this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description, existed prior to the effective date of such person's coverage.

The above provisions also apply to riders attached to this policy. In applying them, the word "rider" will be used for the word "policy".

**GRACE PERIOD.** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. This policy stays in force during Your grace period.

**REINSTATEMENT.** We do not provide for the reinstatement of this policy if it lapses due to nonpayment of premium. If You mail or deliver a premium to Us after the grace period, We will return it to You as soon as We determine the premium is late. No agent is authorized by Us to accept a late premium.

You may reapply for coverage under the Iowa Comprehensive Health Association if You again become eligible; provided 12 months have elapsed since You voluntarily terminated this policy.

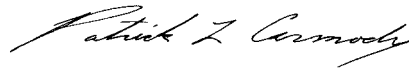
PHYSICAL EXAMINATIONS AND AUTOPSY. We, at Our expense, may have a covered person examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done (at Our expense) where it is not forbidden by law.

MISSTATEMENT OF AGE. If the age of a covered person has been misstated, all benefits payable to that person shall be in the amount the premium paid would have provided at the correct age.

LEGAL ACTIONS. You can not bring a legal action to recover under Your policy for at least 60 days after You have given Us written proof of loss. You can not start such an action more than three years after the date proof of loss is required.

APPEAL PROCESS. If benefits have been denied, You may within 60 days from receipt of the denial apply to the Administrator for reconsideration of the determination. The Administrator shall issue its decision after reconsideration in writing explaining the basis of the determination.

This policy is signed for Us by:



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Patrick L. Carmody  
President, Board of Directors

Specimen



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## APPEALS PROCESS NOTICE

If You are aggrieved by an action or decision of [ICHA], up to three levels of appeals may be pursued. The first two levels are internal appeal processes. The first internal appeal is to [ICHA]. The second internal appeal is to [ICHA's] Grievance Committee. The third level of appeal is an independent external review process. This independent external review process is available only for appeals regarding a Coverage Decision and may be used only after the completion of [ICHA's] internal appeal processes. An expedited review process is also available.

### DEFINITIONS

**Commissioner** means the Iowa Commissioner of Insurance.

**Coverage Decision** means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in the policy as excluded from coverage.

**Independent Review Entity** means a reviewer or entity, certified by the Commissioner pursuant to Iowa law, which includes such entities as medical peer review organizations and nationally recognized health experts or institutions.

**You or Your** means the person named as the Insured on the Policy Schedule. The definition of You or Your also includes your representative.

### APPEALS PROCESS

#### First Level Appeal

You may request an appeal of an action or decision of [ICHA] within ninety (90) days of the event giving rise to the appeal. The appeal request should be submitted in writing to [ICHA] at the address and telephone number listed on Your coverage identification card. The request for an appeal should include:

- (a) a statement that this is a request for an appeal;
- (b) the name and relationship of the person making the appeal;
- (c) the reason for the appeal;
- (d) any information that might help resolve the issue;
- (e) the date of the service or claim; and
- (f) if possible, a copy of the Explanation of Benefits.

Within five (5) business days, [ICHA] will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint, and the resolution requested.

You may submit additional information to [ICHA]. If [ICHA] requests additional information, and/or if outside medical consultation is needed, You will be informed of any resulting delay within ten (10) working days of the date [ICHA] received Your written request for review.

[ICHA] shall review all materials, make a decision, and respond to You in writing within thirty (30) days of receipt of the completed information needed to respond to the appeal.

[ICHA] will notify You of its decision in writing and provide information regarding any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons for the decision and will specifically refer to any supporting documents. If [ICHA] fails to make its decision within thirty (30) days of receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and You may appeal to the next level.

### **First Level Expedited Review**

If an appeal involves denial of coverage of a service and Your treating provider submits written notice to [ICHA] that delay would pose an imminent or serious threat to You, [ICHA] will provide its written decision within 72 hours of receipt of the appeal request.

### **Second Level Appeal**

In any case where the First Level Appeal does not resolve a difference of opinion between You and [ICHA], written notification of a request for appeal to the Grievance Committee must be provided to [ICHA] within ninety (90) days of the date of an adverse decision.

Within five (5) business days, [ICHA] will respond in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested. Within two (2) business days of sending this notice, [ICHA] will forward the appeal, with all relevant information from its files, to the Grievance Committee.

The Grievance Committee will investigate the complaint, consider all information submitted, and make a decision within thirty (30) days of receipt of the complete information needed to respond to the appeal. The Grievance Committee may engage independent medical and legal experts to assist in this review process.

The Grievance Committee will notify You of its decision in writing and inform You of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons for the decision and will specifically refer to any supporting documents. If the Grievance Committee fails to make its decision within thirty (30) days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and You may appeal to the next level.

### **Second Level Expedited Review**

If an appeal involves denial of coverage of a service and Your treating provider submits written notice to [ICHA] that delay would pose an imminent or serious threat to You, the Grievance Committee will provide its written decision within 72 hours of receipt of the appeal request.

### **External Review Process**

Request for External Review. Once all [ICHA] internal appeals processes have been exhausted, You or Your treating provider may file a written request for external review of a Coverage Decision. The request must be filed with the Iowa Insurance Division Commissioner within sixty (60) days of receipt of the final Coverage Decision. The request also must be accompanied with a \$25 fee.

Certification. Within two (2) business days from the receipt of a request to certify an external review, the Commissioner shall certify the request and notify You or Your treating provider and [ICHA] in writing of the certification if all the following criteria are satisfied:

- (a) You were covered by [ICHA] at the time the service or treatment was proposed or received;
- (b) You have been denied based on a determination by [ICHA] that the proposed or received service or treatment does not meet the definition of medical necessity as defined by the policy;
- (c) all internal appeal mechanisms provided under the policy have been exhausted; and
- (d) the written request for external review was filed within sixty (60) days of receipt of the Coverage Decision.

[ICHA'S] Right To Contest Certification Decision. [ICHA] has three (3) business days from the date of receipt to contest the certification decision. If the Commissioner finds that the request for external review is not eligible for certification, the Commissioner shall notify You or Your treating provider of the reasons for the ineligibility by facsimile within two (2) business days of the date of the request for certification. If the Commissioner finds that the request for external review is eligible for certification, the Commissioner shall promptly notify [ICHA] in writing of the reasons for upholding the certification.

[ICHA'S] Obligations in External Review. [ICHA] shall do the following within the later of either three (3) business days of receipt of an eligible request for external review from the Commissioner or three (3) business days of receipt of the Commissioner's denial of [ICHA's] contest of the certification:

- (a) Select an Independent Review Entity from the list certified by the Commissioner. The Independent Review Entity shall be an expert in the treatment of the medical condition under review.
- (b) Notify You and Your treating provider in writing of the name, address, and telephone number of the Independent Review Entity and of Your and Your treating provider's right to submit additional information.

- (c) Notify the selected Independent Review Entity by facsimile that [ICHA] has chosen it to conduct the independent review and provide sufficient descriptive information to identify the type of expert needed to conduct the review.
- (d) Provide the Commissioner by facsimile a copy of the notices sent to You and to the selected Independent Review Entity.

Independent Review Entity's Selection of Reviewer. Within three (3) business days of receipt of the notice of selection, the Independent Review Entity is required to:

- (a) select a person to perform the external review, and
- (b) provide a notice to You and [ICHA] which contains a brief description of the person who will perform the review and the reasons the person selected is an expert in the treatment of the medical condition under review.

Your Right to Object to Independent Review Entity or Reviewer. You or Your treating provider may object to the Independent Review Entity or to the person selected as the reviewer by notifying the Commissioner within ten (10) days of the mailing of the notice by the Independent Review Entity.

The Commissioner has two (2) business days from receipt of the objection to do the following:

- (a) consider the objection;
- (b) approve or deny the objection;
- (c) select a new Independent Review Entity if necessary; and
- (d) provide notice of the Commissioner's decision to You, Your treating health care provider, and to [ICHA].

[ICHA's] Production Requirements. [ICHA] has fifteen (15) days from the date of mailing the notice of the Independent Review Entity, or within three (3) business days of receipt of notice of the Commissioner following an objection by You, whichever is later, to do the following:

- (a) Provide to the Independent Review Entity any information submitted to [ICHA] by You or Your treating provider in support of the request for coverage of the service or treatment under these appeal procedures.
- (b) Provide to the Independent Review Entity any other relevant documents used by [ICHA] or the Administrator in determining whether the proposed service or treatment should have been provided.
- (c) Provide to the Commissioner a confirmation that the information has been provided to the Independent Review Entity, including the date it was provided.

Document Production. You or Your treating provider may provide to the Independent Review Entity any information submitted under [ICHA's] internal review process and other newly discovered relevant information. You have ten (10) business days from the mailing date of the notification of the person selected as the reviewer to provide this information. The Independent Review Entity may determine whether to consider information submitted after this ten-day (10-day) period.

Independent Review Entity's Request for Additional Information. Within five (5) business days of receipt of the documentation regarding the review, the Independent Review Entity is to notify You and Your treating provider of any additional medical information needed in order to conduct the review. Such additional information shall be provided within five (5) days of receipt of the notification requesting the additional information.

Independent Review Entity Decision. The Independent Review Entity is to submit its external review decision as soon as possible but no later than thirty (30) days from the date the Independent Review Entity received the information. The Independent Review Entity may, for good cause, request an extension of time from the Commissioner.

### **External Expedited Review**

If an appeal involves a denial of coverage of a service based upon a medical necessity determination and Your treating provider states that delay would pose an imminent or serious threat to You, Your provider shall immediately contact [ICHA] for an expedited review.

Your treating health care provider and [ICHA] shall select, within 72 hours, an Independent Review Entity to conduct the external review. Your treating health care provider shall notify the Commissioner of the expedited review request following this agreement.

In the event that Your treating health care provider and [ICHA] cannot reach an agreement upon the selection of an Independent Review Entity, Your treating health care provider shall notify the Commissioner who will select the Independent Review Entity.

In the event that [ICHA] does not find that a delay would pose an imminent or serious threat to You, Your treating health care provider may ask the Commissioner to immediately review the request for certification as an expedited review. A review by the Commissioner under this circumstance shall stay the 72-hour expedited review time period.

[ICHA] and Your treating health care provider shall provide any additional medical information to the Independent Review Entity.

**Final External Review Process Decisions**

The review decision by the Independent Review Entity is binding on [ICHA]. You or Your treating provider may appeal an adverse review decision by the Independent Review Entity conducting the review by filing a petition in Polk County District Court or the District Court where You reside.