coOportunity HEALTH sm | University of Iowa Health Alliance

HSA-Qualified Plans

CoOportunity **Preferred HSA**
UI Health Alliance
Outline of Coverage

Featuring UI Health Alliance Providers

Plan Options: Bronze, Silver, Gold
Including Cost Sharing Reduction Plans

Qualified Health Plans for Individuals and Families in Iowa
For coverage beginning January 1, 2014

Plans offered on the Iowa Health Insurance Marketplace and Off Exchange

Offered in Select Counties **IN IOWA**

M-00041 (09/13)

CoOportunity Preferred HSA UI Health Alliance

A CoOportunity Preferred HSA UI Health Alliance Plan is a qualified high-deductible health plan that works in combination with a health savings account (HSA) to help you save and pay for your healthcare. Enrolling in the CoOportunity Preferred HSA UI Health Alliance Plan allows you to pay for qualified medical expenses, such as an office visit, prescription drugs and laboratory tests. Contributions to an HSA are tax deductible and can earn tax-free interest. You decide how and when to pay for your healthcare until you meet your health plan deductible or you may save the funds for future medical expenses. Unlike other reimbursement-type plans, money in an HSA can accumulate indefinitely. After age 65, HSA funds can be used for other purposes, not just medical expenses, without incurring any penalties. CoOportunity Preferred HSA UI Health Alliance is available in select Iowa counties.

Many financial institutions, including credit unions, offer HSAs. In general, any individual who is covered under a high-deductible health plan is eligible to establish an HSA. You are not eligible for an HSA if you are covered by another health plan that is not a high-deductible plan or you are entitled to Medicare, or if you are a dependent on someone else's tax return.

You may contribute up to the maximum federal statutory amount, regardless of your health plan's calendar year deductible amount, into your HSA. Federal statutory amounts for 2014 are $3,300 for single coverage and $6,550 for family coverage.

The CoOportunity Preferred HSA UI Health Alliance plans outlined here and detailed in the Individual Policy and Benefits Chart are designed to provide benefits for medical expenses incurred as a result of a covered illness or injury. Covered services are subject to deductible, coinsurance and copayment provisions, or other limitations set forth in your Policy.

Unless otherwise indicated, CoOportunity Preferred HSA UI Health Alliance plans meet the requirements of the Patient Protection and Affordable Care Act for coverage and out-of-pocket costs. This includes coverage for essential health benefits such as hospitalization, outpatient services, emergency services, maternity and newborn care, mental health services, and prescription drugs. In addition, there are no out-of-pocket costs for preventive services received from in-network providers. Pediatric dental services are not included; this coverage is available as stand-alone plans in the Iowa Health Insurance Marketplace (Exchange).

Types of Enrollment

Single Coverage: Provides coverage to the policyholder only.

Family Coverage: Provides coverage to the policyholder and eligible family members.

Enrollment Periods

Open Enrollment Period. The initial open enrollment period begins on October 1, 2013, and extends through March 31, 2014. Subsequent open enrollment periods will begin on October 15th and extend through December 7th to enroll for the following year. The annual open enrollment period and the date you have to enroll yourself and any eligible dependents are defined under federal law and may vary.

Special Enrollment Period. You are eligible to enroll outside of the open enrollment period if you qualify for a special enrollment period. The following events qualify for a special enrollment period:

You must enroll yourself and any eligible dependents within 30 days if any of these events occur:

- If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.
- If you or your dependent lose group coverage because of the death of the enrollee.
- If you or your dependents lose group coverage because of a divorce or legal separation.
- If your dependent loses group coverage because of loss of eligibility as a dependent child.
- If you or your dependents lose group coverage because the group enrollee's initial enrollment for Medicare.
- For a retired enrollee, spouse and other dependents, if you lose group coverage because of bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

You must enroll yourself and any eligible dependents within 60 days if any of these events occur:

- If you or any of your eligible dependents lose minimum essential coverage (failure to pay premium or a rescission of coverage allowed under federal law do not qualify as a loss of minimum essential coverage).
- Newly acquired dependents through marriage, birth, adoption, or placement for adoption.
- If you become a citizen, national or lawfully present individual in the U.S.

- If you are qualified, but experience an error in enrollment.
- If you are enrolled in another Qualified Health Plan and you successfully demonstrate to the Exchange that your Qualified Health Plan has substantially violated a material provision of its contract.
- If you are newly eligible or lose eligibility for advance payment of the premium tax credit, or you experience a change in eligibility for cost sharing reductions.
- If you become eligible for new Qualified Health Plans offered through the Exchange because of a permanent move.

Late Enrollment. If you do not enroll yourself or any eligible dependents during the annual open enrollment or within 60 days of a special enrollment period, you must wait until the next annual open enrollment period to enroll yourself and any eligible dependents.

Enrollment of Newborn or Newly Adopted Children. Newborn infants and newly adopted children will be covered if enrolled within 60 days of their date of birth or placement for adoption and you make the required payment.

In-Network Providers

CoOportunity Preferred HSA features UI Health Alliance member organizations including four premier healthcare entities in Iowa:

- Genesis Health System, which is based in Davenport and includes four hospitals in Iowa and the Genesis Health Group with more than 160 physicians
- Mercy-Cedar Rapids, which serves the eastern Iowa corridor and includes Mercy Medical Center and a network of 13 family practice clinics and four specialty clinics
- Mercy Health Network, a statewide system comprised of 41 hospitals and 142 physician clinics with 625 physicians
- University of Iowa Health Care, Iowa's only comprehensive academic medical center that includes the state's largest multi-specialty physician group practice with more than 1,400 providers

In addition to UI Health Alliance member organizations, additional facilities, clinics and practitioners in select Iowa counties participate in CoOportunity Preferred.

You must receive healthcare services from a provider that participates in CoOportunity Preferred in order to receive health insurance benefits. Out-of-network coverage is available only for emergencies. CoOportunity Preferred providers agree to accept our payment for covered services and cannot balance bill you for the difference between what is billed and this amount. Please note that you are still responsible for paying network providers for your out-of-pocket costs such as deductibles, copayments, coinsurance and charges for services not covered.

To access the complete directory of CoOportunity Preferred HSA UI Health Alliance providers and review their professional qualifications, visit **coOportunityhealth.com** and choose *"Help Me Find A Doctor or Hospital"* from the home page.

Emergency Coverage

With CoOportunity Preferred HSA UI Health Alliance, there are no out-of-network benefits except for emergencies. In an emergency, out-of-network care will be paid at the in-network benefit level.

Should you need emergency care when traveling for work or while on vacation, you are encouraged to receive care from a provider who contracts with the Midlands Choice Premier, PHCS or the MultiPlan network.

The Midlands Choice Premier network includes hospitals in Iowa, Nebraska and bordering states. The PHCS Network includes providers in all 50 states, and the MultiPlan network is a nationwide provider network that gives access to an additional choice of providers at discounted rates.

To locate a Midlands Choice Premier, PHCS or the MultiPlan network provider, visit **coOportunityhealth.com** and choose *"Help Me Find A Doctor or Hospital"* from the home page.

Terms to know

Network Provider: This is any one of the participating licensed physicians, dentists, mental and chemical health or other healthcare providers, facilities and pharmacies listed in the network directory, that has entered into an agreement with Midlands Choice to provide healthcare services to CoOportunity Health members. This plan is an open-access plan which means you can access any network provider without a referral from a primary care provider or the health plan.

Primary Care Providers: These are providers in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Adolescent Medicine, Adult Medicine and Geriatrics. Members of this plan have access to these providers without a referral or authorization from the plan.

Specialty Care Providers: These providers practice in the specialty and subspecialty categories including, but are not limited to: Allergy/Immunology, Behavioral Medicine, Cardiology, Gastroenterology, Neurology, Oncology, Orthopedics, Pulmonology, Surgery. Members of this plan have access to these providers without a referral or authorization from the plan.

CoOportunity Preferred HSA UI Health Alliance Plan Comparison Chart

Out-of-Pocket Costs for CoOportunity Preferred HSA UI Health Alliance Plans (QHPs) Available on the Iowa Health Insurance Marketplace (Exchange) and Off-Exchange

Plan Benefits	Bronze HSA		Silver HSA		Gold HSA	
Deductible (Individual/Family)	$4,500/$9,000		$2,250/$4,500		$1,400/$2,800	
Coinsurance	30%		20%		20%	
Out-of-Pocket Max (Individual/Family)	$6,350/$12,700		$4,500/$9,000		$2,000/$4,000	
Medical Benefits	✔= Deductible Applies		✔= Deductible Applies		✔= Deductible Applies	
Preventive Care/Screenings/ Immunizations	$0		$0		$0	
First Three Office Visits Free	No		No		No	
Primary Care Visits	$0 copay after deductible	✔	$0 copay after deductible	✔	$15 copay after deductible	✔
Specialist Visits	$0 copay after deductible	✔	$0 copay after deductible	✔	$30 copay after deductible	✔
Behavioral Health (Inpatient)	30%	✔	20%	✔	20%	✔
Behavioral Health (Outpatient)	$0 copay after deductible	✔	$0 copay after deductible	✔	$15 copay after deductible	✔
Habilitative & Rehabilitative Services (Physical Therapy, Occupational Therapy, Speech Therapy)	$0	✔	$0 copay after deductible	✔	$15 (Primary Care) after deductible $30 (Specialist) after deductible	✔
Laboratory Services (Outpatient)	30%	✔	20%	✔	20%	✔
X-Ray/Diagnostic Imaging	30%	✔	20%	✔	20%	✔
High-Tech Imaging (MRI/CT/PET)	30%	✔	20%	✔	20%	✔
Emergency Room Services (Waived If Admitted)	$250 plus coinsurance	✔	$250 plus coinsurance	✔	$250 plus coinsurance	✔
Home Health Care	30%	✔	20%	✔	20%	✔
Inpatient Admission	30%	✔	20%	✔	20%	✔
Outpatient Services	30%	✔	20%	✔	20%	✔
Skilled Nursing Care	30%	✔	20%	✔	20%	✔
Hospice	30%	✔	20%	✔	20%	✔
Durable Medical Equipment	30%	✔	20%	✔	20%	✔
Prescription Drug Benefits	✔= Deductible Applies		✔= Deductible Applies		✔= Deductible Applies	
Generic Drugs	$10	✔	$10	✔	$10	✔
Preferred Brand Drugs	$40	✔	$40	✔	$40	✔
Non-Preferred Brand Drugs	$80	✔	$80	✔	$80	✔
Specialty Drugs	$150	✔	$150	✔	$150	✔
Routine Pediatric Vision Services	✔= Deductible Applies		✔= Deductible Applies		✔= Deductible Applies	
Eye Exam	$0		$0		$0	
Prescription Glasses & Frames (Limit One Pair Per Year)	30%	✔	20%	✔	20%	✔
Out-of-Network Benefits	Not available except in the case of an emergency. In an emergency, out-of-network care will be paid at the in-network benefit level.					

CoOportunity Preferred HSA UI Health Alliance plans do not include pediatric dental services. This coverage is available on the Iowa Health Insurance Marketplace and can be purchased as stand-alone coverage.

The entire family deductible must be met before benefits are paid for any family member with the exception of routine preventive services.

Deductibles, copays and coinsurance apply toward the out-of-pocket maximum.

CoOportunity Preferred HSA UI Health Alliance Plan Comparison Chart

Out-of-Pocket Costs for CoOportunity Preferred HSA UI Health Alliance Cost Sharing Reduction Qualified Health Plans (QHPs) Available ONLY Through the Iowa Health Insurance Marketplace (Exchange)

CoOportunity Preferred HSA UI Health Alliance benefit designs displayed below are available for enrollment ONLY through the Iowa Health Insurance Marketplace. You must meet income requirements in order to enroll in these plans.

	Available only on Iowa Health Insurance Marketplace					
Plan Benefits	**HDHP Silver CSR94***		**HDHP Silver CSR87***		**HSA Silver CSR73**	
Deductible (Individual/Family)	$200/$400		$600/$1,200		$1,700/$3,400	
Coinsurance	10%		10%		20%	
Out-of-Pocket Max (Individual/Family)	$400/$800		$1,200/$2,400		$3,400/$6,800	
Medical Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Preventive Care/Screenings/ Immunizations	$0		$0		$0	
Primary Care Visits	$0 copay after deductible	✔	$0 copay after deductible	✔	$0 copay after deductible	✔
Specialist Visits	$0 copay after deductible	✔	$0 copay after deductible	✔	$0 copay after deductible	✔
Behavioral Health (Inpatient)	10%	✔	10%	✔	$20%	✔
Behavioral Health (Outpatient)	$0 copay after deductible	✔	$0 copay after deductible	✔	$0 copay after deductible	✔
Habilitative & Rehabilitative Services (Physical Therapy, Occupational Therapy, Speech Therapy)	$0 copay after deductible	✔	$0 copay after deductible	✔	$0 copay after deductible	✔
Laboratory Services (Outpatient)	10%	✔	10%	✔	20%	✔
X-Ray/Diagnostic Imaging	10%	✔	10%	✔	20%	✔
High-Tech Imaging (MRI/CT/PET)	10%	✔	10%	✔	20%	✔
Emergency Room Services (Waived If Admitted)	$250 plus coinsurance	✔	$250 plus coinsurance	✔	$250 plus coinsurance	✔
Home Health Care	10%	✔	10%	✔	20%	✔
Inpatient Admission	10%	✔	10%	✔	20%	✔
Outpatient Services	10%	✔	10%	✔	20%	✔
Skilled Nursing Care	10%	✔	10%	✔	20%	✔
Hospice	10%	✔	10%	✔	20%	✔
Durable Medical Equipment	10%	✔	10%	✔	20%	✔
Prescription Drug Benefits	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Generic Drugs	$10	✔	$10	✔	$10	✔
Preferred Brand Drugs	$40	✔	$40	✔	$40	✔
Non-Preferred Brand Drugs	$80	✔	$80	✔	$80	✔
Specialty Drugs	$150	✔	$150	✔	$150	✔
Routine Pediatric Vision Services	✔ = Deductible Applies		✔ = Deductible Applies		✔ = Deductible Applies	
Eye Exam	$0		$0		$0	
Prescription Glasses & Frames (Limit One Pair Per Year)	10%	✔	10%	✔	20%	✔
Out-of-Network Benefits	Not available except in the case of an emergency. In an emergency, out-of-network care will be paid at the in-network benefit level.					

*Because of the low deductibles, the HDHP Silver CSR94 and HDHP Silver CSR87 are not HSA compatible and do not qualify as HSA-qualified HDHPs.
The entire family deductible must be met before benefits are paid for any family member with the exception of routine preventive services.
Deductibles, copays and coinsurance apply toward the out-of-pocket maximum.

For individuals and families of American Indian or Alaskan Native ethnicity

If you are a member of a federally-recognized Indian tribe or Alaska native tribal entity, you qualify to enroll in unique, low cost health insurance products that are only available to American Indians or Alaska Natives. CoOportunity Health offers these special plans on the Health Insurance Marketplace (Exchange). Please go to the Iowa Health Insurance Marketplace at **healthcare.gov** to enroll.

Prescription Drug Coverage

CoOportunity Preferred HSA UI Health Alliance plans include benefits for prescription drugs and medications that are self-administered or administered in a physician's office. Certain off-label uses are covered as specified in the policy and benefits chart. In-network and non-network benefits apply to coverage for prescription drug categories such as:

- Outpatient drugs
- Contraceptive drugs
- Tobacco cessation products (must be prescribed by a licensed provider)
- Mail order drugs
- Specialty drugs that are self-administered
- Drugs for treatment of growth deficiency

Prescription Drug Benefit Design

Prescription drug benefits are based on CoOportunity's EnhancedRx Drug List which is structured in four categories or "tiers." The copay amounts you pay for each 31-day retail supply of your covered prescription drug depends on the tier in which your medication is listed. To access the drug formulary, go to **coOportunityhealth.com** and choose *"Help Me Find a Drug on Drug List"* from the home page. Copayments apply toward out-of-pocket maximum.

Generic Formulary Drugs	Formulary Preferred Brand-Name Drugs	Non-formulary Brand-Name Drugs	Specialty Drugs
$10 copay after deductible met	$40 copay after deductible met	$80 copay after deductible met	$150 copay after deductible met

Retail Pharmacies

MedImpact is the pharmacy benefits manager (PBM) for CoOportunity Health. The MedImpact network includes over 66,000 retail pharmacies across the U.S. Take your prescription to a participating MedImpact pharmacy and show the pharmacist your CoOportunity Health ID card. You pay the appropriate copay amount (see table) based on how the medication is classified.

Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand-name drug, even when a generic is appropriate, you will be responsible for the difference in cost plus the applicable copay amount.

Mail Order Service

Outpatient prescription drugs may be ordered through the CoOportunity Health mail order service. If you order a 93-day supply, or portion thereof, we cover 100% of the allowed amount, subject to your deductible and copayment of $20 for generic formulary drugs and $80 for brand-name formulary drugs. Non-formulary drugs are covered subject to a copayment of $240. Specialty drugs are not available through the mail order service. Enrollment information about this service can be found at **coOportunityhealth.com**.

Specialty & Growth Deficiency Drugs

Specialty drugs are limited to drugs on the specialty drug list and growth deficiency drugs are limited to drugs on the growth deficiency drug list; all drugs in these categories must be obtained from CoOportunity's specialty drug vendor, CVS Caremark Specialty Pharmacy. More information about ordering specialty drugs can be found at **coOportunityhealth.com**.

Quantity Limits & Prior Authorizations

Drugs covered under your benefits policy may be limited per month, benefit period, or lifetime by specific quantity limitations. These limitations are determined by CoOportunity Health based on medical necessity. In addition, certain drugs may require prior authorization to verify that the drug is medically necessary and part of a specific treatment plan; your healthcare provider must call to obtain approval. For a list of drugs subject to quantity limits, or to determine whether a drug you are taking requires prior authorization, check with your pharmacist or provider, contact Member Services or go to **coOportunityhealth.com**.

Terms to Know

Brand Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand drug has expired. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Generic Drug: A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand drug. Generally, generic drugs cost less than brand drugs. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Drug Formulary: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies covered by us as indicated in the Benefits Chart which are covered at the highest benefit level. Some drugs on the formulary may require authorization to be covered as formulary drugs. To review the drug formulary, go to **coOportunityhealth.com** and click on *"Help Me Find a Drug on Drug List."*

Non-Formulary Drug: This is a medically necessary prescription drug which is not on the formulary and is not investigative or otherwise excluded under the Policy.

Specialty Drug List: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. Specialty drugs are covered by us as indicated in the Prescription Drug Services section. The specialty drug list is available by calling Member Services, or logging on to your account at **coOportunityhealth.com**.

Covered Benefits

Unless otherwise indicated, CoOportunity Preferred HSA UI Health Alliance plans meet the requirements of the Patient Protection and Affordable Care Act for coverage and out-of-pocket costs. This includes coverage for essential health benefits such as hospitalization, outpatient services, emergency services, maternity and newborn care, mental health services, and prescription drugs. In addition, there are no out-of-pocket costs for preventive services.

Inpatient Hospital Services

Coverage is provided for medically necessary services and supplies related to the treatment of illness or injury in an inpatient facility. Benefits are available for, but not limited to, the following covered services:

- Anesthesia
- Intensive care facilities
- General nursing care
- Laboratory and diagnostic imaging services
- Newborn nursery facilities
- Other diagnostic or treatment-related hospital services
- Physician and other professional medical and surgical services provided while in the hospital
- Physical therapy
- Prescription drugs or other medications administered during treatment
- Radiation therapy
- Room and board
- Use of operating or maternity delivery rooms
- Rehabilitative and habilitative services

Outpatient, Ambulatory or Surgical Facility Services

Coverage includes the use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities. Other covered services are:

- Anesthesia
- Blood and blood products (unless replaced), and blood derivatives
- Drugs administered during treatment
- General nursing care
- Laboratory and diagnostic imaging services
- Other diagnostic or treatment related outpatient services
- Physician and other professional medical and surgical services provided while an outpatient
- Physical therapy
- Radiation therapy
- Rehabilitative and habilitative services

Healthcare Provider Office or Clinic Visit

In addition to the office visit, benefits are available for (but not limited to) the following covered services when medically necessary:

- Allergy testing (based on established medical policies) and treatment, including injections
- Blood and blood products (unless replaced) and blood derivatives
- Diagnosis and treatment of illness or injury to the eyes (initial evaluation, lenses and fitting for contact or eyeglass lenses when prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconous)
- Professional medical and surgical services and related supplies from physicians and other health care providers
- All other injections

Preventive and Wellness Services

Under the Affordable Care Act, many routine preventive services are fully (100 percent) covered and your deductible does not apply, as long as you use network benefits. Those services are:

- Routine health exams and periodic health assessments. A physician or healthcare provider will counsel you as to how often health assessments are needed based on your age, gender and health status.
- Child health supervision services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child.
- Routine prenatal services and exams to include visit-specific screening tests, education and counseling.

- Routine postnatal services and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
- Routine screening procedures for cancer, including colorectal cancer, breast cancer and cervical cancer.
- Routine eye and hearing exams for children under 22.
- Professional voluntary family planning services.
- Adult immunizations.
- Women's preventive health services, including mammograms, BRCA testing and genetic counseling for women who are at higher risk, screenings for cervical cancer, breast pumps, human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling (see prescription drug services section for coverage of contraceptive drugs)
- Obesity screening, counseling and management for all ages during a routine preventive care exam. If you are an adult age 18 or older and have a body mass index (BMI) of 30 or more, we also cover intensive obesity management to help you lose weight. Your primary care doctor can coordinate these services.

A detailed listing of preventive services provided at no cost share for adults, women and children is provided on page 11.

Behavioral Health Services

Benefits are available for medically necessary professional mental health services for evaluation, crisis intervention and treatment of mental health disorders for individuals, groups and families. A diagnostic assessment by a mental health professional will include recommendations regarding appropriate inpatient or outpatient treatment and services. Coverage also includes medically necessary services for assessments for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the appropriate state agency.

Transplant Services

Benefits are available for services associated with medically-necessary organ and tissue transplant, including, but not limited to, kidney, cornea, heart, lung, heart-lung, pancreas and pancreas-kidney. Benefits also are available for bone marrow transplants, including allogeneic and autologous stem cell transplants. Charges for transplant services must be incurred at a designated transplant center to receive in-network benefits. Donor medical and hospital expenses are covered only when the recipient is covered under the Policy and the transplant and directly-related donor expenses have received prior authorization for coverage. Medical complications experienced by the donor are not covered if they are not a member on the Policy.

Home Health Services

Benefits are available for skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns (including supplies and equipment), home health aide services and other eligible home health services when provided in your home, if you are homebound (i.e., unable to leave home without considerable effort due to a medical condition; lack of transportation does not constitute homebound status).

We cover private duty nursing when provided by an approved home health agency and precertified as medically necessary.

We cover palliative care benefits, including symptom management, education and establishing goals of care. The requirement that you be homebound for a limited number of home visits for palliative care (as shown in the schedule of payments) is waived if you have a life-threatening, non-curable condition that has a prognosis of survival of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy also are covered. IV line care kits are covered under Durable Medical Equipment. You do not need to be homebound to receive TPN/IV therapy.

Hospice Services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include in-patient services (through a hospice facility), home health services (part-time or continuous care, as medically necessary) from an interdisciplinary hospice team (physician, nurse, social worker and/or spiritual counselor), as well as respite care. Medically necessary medications for pain and symptom management, semi-electric hospital beds and other durable medical equipment, and emergency and non-emergency care may also be covered.

Emergency and Urgently Needed Care Services

Coverage is provided for emergency care to treat the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or a condition requiring professional health services immediately necessary to preserve life or stabilize health. Urgently needed care are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration of your health, and which cannot be delayed until the next available clinic or office hours.

Other Covered Services

Refer to the Individual Policy and Benefits Chart for a complete description of other covered services. A brief summary includes:

- Ambulance and medical transportation services
- Durable medical equipment, prosthetics, orthotics and supplies
- Bariatric surgery
- Health education for preventive services and education for the management of chronic health problems
- Laboratory services when ordered by a provider
- Accidental, medical referral dental services, oral surgery; treatment of cleft lip and cleft palate of a dependent child
- Mastectomy reconstruction including lymphedemas
- Non-surgical musculoskeletal treatment of ailments to the musculoskeletal system such as manipulations or related procedures
- Pediatric eyewear for children under 19
- Physical therapy, occupational therapy and speech therapy services when medically necessary to correct effects of illness or injury, or habilitative care rendered for congenital, developmental or medical conditions
- Temporomandibular Disorder (TMD)

Important Terms to Know

Calendar Year Deductible: The deductible is the fixed dollar amount you pay for covered services each calendar year before benefits are available. There are individual and family deductibles.*

Family Deductible: The family deductible is equal to two times the individual deductible for in-network covered services unless otherwise indicated on your benefits chart. When a plan covers more than one person in a family, the benefits will begin for all family members once the family deductible is met. This is known as an aggregate medical deductible. Out-of-pocket maximum amounts are also aggregate, requiring the family out-of-pocket maximum to be met before services are paid in full for any single family member.*

Copayment and Coinsurance: For some services, you are responsible for paying a copayment until you reach your out-of-pocket maximum. For other services, you must meet your deductible before coverage begins. Once you meet your calendar year deductible, you are responsible for paying copayments or a certain percentage of your covered charges (coinsurance) until you reach your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you pay nothing for covered services for the rest of the calendar year. Copayment amounts for office visits and prescription drugs apply toward out-of-pocket maximum.

Please refer to the charts on pages 4 and 5 to determine the deductible and coinsurance amounts. Covered services or items requiring a copayment or coinsurance are specified in the Individual Policy. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.*

Allowed Amount: For covered services delivered by participating network providers, payment is based on the provider's discounted charge (allowed amount).

For covered services delivered by non-network providers, the allowed amount is based on the usual and customary amount. You are responsible for any charges above the allowed amount for services provided by a non-contracting provider. This is called balance billing.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly premium payments.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100 percent of the allowed amount for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded. Non-network benefits above the allowed amount (see definition of allowed amount above) do not apply to the out-of-pocket limit.

Qualified Health Plan: CoOportunity Preferred HSA UI Health Alliance is a health plan that has been certified by the Iowa Health Insurance Marketplace (Exchange), provides essential health benefits, follows established limits on cost-sharing and meets other requirements defined in the Affordable Care Act.

***Please note:** The deductible and out-of-pocket maximum for qualified high deductible health plans are increased annually to conform to cost-of-living adjustments permitted by section 223 of the Internal Revenue Code and subsequent amendments.

Preventive Services Covered with No Cost-Sharing

The Affordable Care Act requires that private insurers cover certain preventive services without any patient cost-sharing. This summary of selected preventive services provides a listing of services that are covered by all CoOportunity Preferred HSA UI Health Alliance plans without your having to pay a copayment or coinsurance or meet your deductible. This applies only when these services are delivered by an in-network provider. For a complete description of preventive services, refer to the Individual Policy and/or Benefits Chart provided when you enroll in a plan.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm:** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse:** screening and counseling
- **Aspirin:** use for men and women of certain ages
- **Blood Pressure:** screening for all adults
- **Cholesterol:** screening for adults of certain ages or at higher risk
- **Colorectal Cancer:** screening for adults over 50
- **Depression:** screening for adults
- **Type 2 Diabetes:** screening for adults with high blood pressure
- **Diet:** counseling for adults at higher risk for chronic disease
- **HIV:** screening for all adults at higher risk
- **Immunization:** vaccines for adults — doses, recommended ages, and recommended populations vary; an immunizations and vaccine schedule is provided upon request.
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Meningococcal
  - Pneumococcal
  - Varicella
  - Herpes Zoster
  - Tetanus, Diphtheria, Pertussis
  - Measles, Mumps, Rubella
- **Obesity:** screening and counseling for all adults
- **Sexually Transmitted Infection (STI):** prevention counseling for adults at higher risk
- **Tobacco Use:** screening for all adults and cessation interventions for tobacco users
- **Syphilis:** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia:** screening on a routine basis for pregnant women
- **Bacteriuria:** urinary tract or other infection screening for pregnant women
- **BRCA:** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography:** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention:** counseling for women at higher risk
- **Breastfeeding:** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer:** screening for sexually active women
- **Chlamydia Infection:** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and interpersonal violence:** screening and counseling for all women
- **Folic Acid:** supplements for women who may become pregnant
- **Gestational diabetes:** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea:** screening for all women at higher risk
- **Hepatitis B:** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV):** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis:** screening for women over age 60 depending on risk factors
- **Rh Incompatibility:** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use:** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI):** counseling for sexually active women
- **Syphilis:** screening for all pregnant women or other women at increased risk
- **Well-woman visits:** to obtain recommended preventive services

Covered Preventive Services for Children

- **Alcohol and Drug Use:** assessments for adolescents
- **Autism:** screening for children at 18 and 24 months
- **Behavioral assessments for children of all ages:** 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Blood Pressure:** screening for children 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Cervical Dysplasia:** screening for sexually active females
- **Congenital Hypothyroidism:** screening for newborns
- **Depression:** screening for adolescents
- **Developmental screening** for children under age 3, and surveillance throughout childhood
- **Dyslipidemia screening** for children at higher risk of lipid disorders; ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Fluoride Chemoprevention supplements** for children without fluoride in their water source
- **Gonorrhea:** preventive medication for the eyes of all newborns
- **Hearing:** screening for all newborns
- **Height, Weight and Body Mass Index measurements** for children ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Hematocrit or Hemoglobin:** screening for children
- **Hemoglobinopathies or sickle cell screening** for newborns
- **HIV screening** for adolescents at higher risk
- **Immunization vaccines** for children — doses, recommended ages, and recommended populations vary; an immunizations and vaccine schedule is provided upon request.
  - Hepatitis A
  - Hepatitis B
  - Inactivated Poliovirus
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Varicella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Haemophilus influenzae type b
  - Tetanus, Diphtheria, Pertussis
  - Measles, Mumps, Rubella
- **Iron supplements** for children ages 6 to 12 months at risk for anemia
- **Lead screening** for children at risk of exposure
- **Medical History** for all children throughout development ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Obesity screening** and counseling
- **Oral Health risk assessment** for young children ages 0 to 11 months, 1 to 4 years, 5 to 10 years
- **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
- **Tuberculin testing** for children at higher risk of tuberculosis ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Vision screening** for all children

Notification Requirements

The following are requirements you or your CoOportunity Preferred HSA UI Health Alliance provider must follow to receive the maximum benefits available under your contract.

Summary of Utilization Management Programs

CoOportunity Health utilization management programs help ensure effective, accessible and high quality healthcare. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of healthcare services. These programs include:

- Inpatient concurrent review and care coordination to support timely care and ensure a safe and timely transition from the hospital
- "Best practice" care guidelines for selected kinds of care
- Outpatient case management to provide care coordination
- The CareCheck® program to coordinate out-of-network medical emergencies

In-Network Inpatient Hospital Admissions

CoOportunity Health must be notified of all non-maternity inpatient hospital admissions. This enables us to coordinate discharge planning, case management and disease management services with our patient providers. If the patient is hospitalized in a contracting UI Health Alliance hospital in Iowa, notification will be provided by the hospital. If the patient is hospitalized in a non-network hospital in Iowa, or is admitted to an inpatient facility in another state, CoOportunity Health must be notified by you or your provider.

Your Policy provides coverage for services from a network of participating providers and facilities (physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies) with which CoOportunity Health has contractual agreements. A current list of network physicians, providers or facilities that are authorized to provide certain covered services as described in the Individual Policy. To obtain network benefits for covered services, you must receive services from your network providers. There are limited exceptions as described in the Policy. You can view a provider directory at any time by logging on to **coOportunityhealth.com** and clicking on *"Help Me Find A Doctor or Hospital"* from the home page. You also may call Member Services and request a paper copy.

Out-of-Network Services

You have no out-of-network benefits except for emergencies. Should you need to receive care in an emergency from an out-of-network provider, it is your responsibility to call CareCheck® to receive certification from a utilization management specialist as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to receiving emergency care. The CareCheck number is provided on the back of your member ID card and in the Individual Policy document.

Prior Authorizations

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate this authorization process with CoOportunity Health. A listing of services that require prior authorizations may be obtained by contacting Member Services or on **coOportunityhealth.com**.

Limitations & Exclusions

In addition to any other benefit exclusions, limitations or terms, CoOportunity Preferred HSA UI Health Alliance health plans will not cover charges incurred for any of the following services:

- **Pediatric dental services: this plan does not include pediatric dental services as required under the ACA. This coverage is available on the Iowa Health Insurance Marketplace and can be purchased as stand-alone coverage.**
- Treatment, procedures or services or drugs that are not medically necessary and/or which are primarily educational in nature or for your vocation, comfort, convenience, appearance, or recreation, including skills training.
- Procedures, technologies, treatments, facilities, equipment, drugs and devices that are considered investigative, or otherwise not clinically accepted medical services. We consider vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and do not cover these services. We also consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in your Policy. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
- Rest and respite services and custodial care, except as respite services are specifically described in the Benefits Chart under the subsection "Hospice Services." This includes all services, medical equipment and drugs provided for such care.
- Halfway houses, extended care facilities, or comparable facilities, residential treatment services, except as specifically described in the Individual Policy and Benefits Chart.
- Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
- Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under your Policy.
- Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
- Cosmetic surgery, cosmetic services and treatments primarily for the improvement of your appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for reconstructive surgery.
- Dental treatment, procedures or services not listed in your Individual Policy and Benefits Chart.
- Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
- Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
- Court ordered treatment.
- Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) intracytoplasmic sperm injection (ICSI), and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.

- Services and/or surgery for gender reassignment, unless determined medically necessary.
- Routine foot care, unless the services meet our criteria for medically necessary care.
- Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Policy. This exclusion does not apply to pediatric eyewear or cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or logging on to **coOportunityhealth.com**.
- Medical food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula. This exclusion does not apply to oral amino acid based elemental formula if it meets our medical coverage criteria.
- Genetic counseling and genetics studies except when the results would influence a treatment or management of a condition or family planning decision. Our medical policies (medical coverage criteria) are available by calling Member Services, or logging on to **coOportunityhealth.com**.
- Services provided by a family member of the enrollee, or a resident in the enrollee's home.
- Religious counseling; marital/relationship counseling and sex therapy.
- Services that are provided to you, if you also have other primary insurance coverage for those services and you do not provide us the necessary information to pursue Coordination of Benefits, as required under your Policy.
- For non-network benefits, the portion of a billed charge for an otherwise covered service by a provider, which is in excess of the allowed amount. We also do not cover charges or a portion of a charge that is either a duplicate charge for a service or charges for a duplicate service.
- Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which you are not obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the insured, except in cases of undue financial hardship.
- Provider and/or insured travel and lodging incidental to travel, regardless if it is recommended by a physician.
- Health club memberships.
- Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term or if the pregnancy is a result of rape or incest.
- Massage therapy.
- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
- Autopsies.
- Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond 12 months from the date of the injury, (4) received beyond the initial treatment or restoration, or (5) received beyond twenty-four months from the date of injury.
- Nonprescription (over the counter) drugs or medications, unless listed on the formulary drug list and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. We cover off-label use of drugs to treat HIV/AIDS and cancer as specified in the "Prescription Drug Services" section of this Policy. The formulary drug list is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies. The formulary drug list is available by calling Member Services, or logging on to **coOportunityhealth.com**. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Insured obtains a prescription for the item.
- Non-medical administrative fees and charges including but not limited to medical record preparation charges, appointment cancellation fees, after hours appointment charges and interest charges.
- Charges for sales tax.
- Charges for elective home births.
- Professional services associated with substance abuse interventions. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this Policy to seek substance abuse treatment.
- Services provided by naturopathic providers.

- Oral surgery to remove wisdom teeth.
- Acupuncture.
- All drugs used for sexual dysfunction.
- All drugs used for the treatment of infertility.
- Orthognathic treatment or procedures and all related services.
- Commercial weight loss programs and exercise programs.
- Treatment, procedures, or services or drugs which are provided when you are not covered under your Policy.
- Routine eye exams for adults age 22 and older.
- Routine hearing exams for adults age 22 and older.
- Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas.

Read your policy carefully

This Outline of Coverage provides you with a brief description of CoOportunity Preferred HSA UI Health Alliance plan features and coverage. This is not your policy. Only the actual benefit provisions in your policy determine your benefits. The policy details your rights and obligations, as well as CoOportunity Health's rights and obligations. In the event discrepancies arise with the information in this document, the terms and conditions of your policy will govern. Therefore, it is important that you read your policy carefully.

For more complete information about this health plan, including benefits, exclusions and limitations, please refer to the CoOportunity Preferred HSA UI Health Alliance Individual Policy and Benefits Chart, which will be available when you become an enrolled member.

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Connect with us

If you need assistance selecting a plan or have questions, call our Individual Sales Hotline toll-free at 1.866.217.6111, Mon–Fri, 8 a.m. – 6 p.m.