

CVCH Health Plans

Major medical insurance for
groups of 2–50 employees

Cedar Valley Community Healthcare (CVCH) specializes in meeting the needs of small employers. As a locally owned and operated health plan, CVCH is well-suited to work with companies in the Cedar Valley. At CVCH, our experience and industry knowledge allow us to create affordable solutions for your health insurance concerns. We provide competitively priced health insurance plans with hometown value through prompt and personal local service.



Cedar Valley Community Healthcare manages and distributes this health insurance plan that is underwritten by Madison National Life Insurance Company, Inc., a Wisconsin insurance company. Madison National Life is a member of The IHC Group, an insurance organization composed of Independence Holding Company (NYSE:IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance solutions for nearly 30 years.



CVCH Health Plans	Bronze
Calendar-year maximum	\$5 million
Physician office visit	Covered charges apply to deductible and coinsurance
Deductible The deductible options listed apply per covered person, per calendar year to in-network charges. In-network and out-of-network deductibles accumulate separately. However, when the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	D \$500 D \$1,500 D \$2,500 D \$7,500 D \$1,000 D \$2,000 D \$5,000 D \$10,000 Family deductible: Two times the individual deductible amount Out-of-network deductible: Two times the in-network deductible amount
Coinsurance After the deductible has been satisfied, the plan will pay the selected coinsurance percentage of covered in-network charges.	D 80% D 70% D 60% Out-of-network coinsurance: 60% when the 80% in-network coinsurance is selected, 50% when the 70% or 60% in-network coinsurance is selected
Coinsurance out-of-pocket maximum¹ In addition to the deductible, the insured person is responsible for the selected out-of-pocket amount per calendar year for in-network charges. In-network and out-of-network out-of-pocket amounts accumulate separately. However, when the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	With the 80% coinsurance: D \$500 D \$1,500 D \$3,000 D \$1,000 D \$2,000 With the 70% coinsurance: D \$1,500 D \$2,250 D \$3,000 With the 60% coinsurance: D \$2,000 D \$3,000 Family out-of-pocket: Two times the individual out-of-pocket Out-of-network out-of-pocket: Two times the in-network out-of-pocket
Outpatient diagnostic lab and X-ray	Covered charges apply to deductible and coinsurance
Emergency room The copay will be waived if admitted inpatient immediately following the emergency room visit.	\$150 copay After the copay, the plan pays 100% of the emergency room covered charges.
Emergency ambulance services Coverage includes ground, air and water ambulance services.	\$150 copay After the copay, the plan pays 100% of the ambulance service covered charges.
Prescription drug coverage For covered prescription drugs obtained through mail-order, two copays apply for a 90-day supply.	D A: Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay D B: \$50 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay D C: \$100 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay D No prescription drug coverage; outpatient prescription drugs are excluded from the insurance coverage and expenses are not applied to deductible or coinsurance

¹ Expenses incurred for the following charges do not accumulate toward the out-of-pocket maximum: outpatient treatment of mental, nervous or chemical dependency disorders; precertification deductibles; copays; deductible amounts; and charges excluded under the policy.

Silver	Gold
\$5 million	\$5 million
<p>\$20 copay per in-network office visit</p> <p>After the copay, the plan pays 100% of the office visit charge.²</p> <p>Out-of-network visit: Covered charges apply to the out-of-network deductible and coinsurance</p>	<p>D \$20 copay D \$30 copay</p> <p>Copay applies per in-network office visit. After the copay, the plan pays 100% of the office visit charge and diagnostic labs or X-rays performed in connection with the office visit.²</p> <p>Out-of-network visit: Covered charges apply to the out-of-network deductible and coinsurance</p>
<p>D \$500 D \$1,500 D \$2,500 D \$7,500</p> <p>D \$1,000 D \$2,000 D \$5,000 D \$10,000</p> <p>Family deductible: Two times the individual deductible amount</p> <p>Out-of-network deductible: Two times the in-network deductible amount</p>	<p>D \$500 D \$1,500 D \$2,500 D \$7,500</p> <p>D \$1,000 D \$2,000 D \$5,000 D \$10,000</p> <p>Family deductible: Two times the individual deductible amount</p> <p>Out-of-network deductible: Two times the in-network deductible amount</p>
<p>D 80% D 70% D 60%</p> <p>Out-of-network coinsurance: 60% when the 80% in-network coinsurance is selected, 50% when the 70% or 60% in-network coinsurance is selected</p>	<p>D 80% D 70% D 60%</p> <p>Out-of-network coinsurance: 60% when the 80% in-network coinsurance is selected, 50% when the 70% or 60% in-network coinsurance is selected</p>
<p>With the 80% coinsurance:</p> <p>D \$500 D \$1,500 D \$3,000</p> <p>D \$1,000 D \$2,000</p> <p>With the 70% coinsurance:</p> <p>D \$1,500 D \$2,250 D \$3,000</p> <p>With the 60% coinsurance:</p> <p>D \$2,000 D \$3,000</p> <p>Family out-of-pocket: Two times the individual out-of-pocket</p> <p>Out-of-network out-of-pocket: Two times the in-network out-of-pocket</p>	<p>With the 80% coinsurance:</p> <p>D \$500 D \$1,500 D \$3,000</p> <p>D \$1,000 D \$2,000</p> <p>With the 70% coinsurance:</p> <p>D \$1,500 D \$2,250 D \$3,000</p> <p>With the 60% coinsurance:</p> <p>D \$2,000 D \$3,000</p> <p>Family out-of-pocket: Two times the individual out-of-pocket</p> <p>Out-of-network out-of-pocket: Two times the in-network out-of-pocket</p>
<p>Covered charges apply to deductible and coinsurance</p>	<p>Covered charges apply to deductible and coinsurance unless these services are provided the same day as an in-network physician office visit.</p>
<p>\$150 copay</p> <p>After the copay, the plan pays 100% of the emergency room covered charges.</p>	<p>\$150 copay</p> <p>After the copay, the plan pays 100% of the emergency room covered charges.</p>
<p>\$150 copay</p> <p>After the copay, the plan pays 100% of the ambulance service covered charges.</p>	<p>\$150 copay</p> <p>After the copay, the plan pays 100% of the ambulance service covered charges.</p>
<p>D A: Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D B: \$50 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D C: \$100 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D No prescription drug coverage; outpatient prescription drugs are excluded from the insurance coverage and expenses are not applied to deductible or coinsurance</p>	<p>D A: Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D B: \$50 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D C: \$100 prescription deductible per covered person, per calendar year then ... Generic: \$7 copay Brand-name formulary: \$25 copay Brand-name non-formulary: \$45 copay</p> <p>D No prescription drug coverage; outpatient prescription drugs are excluded from the insurance coverage and expenses are not applied to deductible or coinsurance</p>

² Other covered service performed during the visit are subject to deductible and coinsurance.

CVCH Health Plan	Platinum (Qualified High-Deductible Health Plan)*																								
Calendar-year maximum	\$5 million																								
Physician office	Covered charges apply to deductible and coinsurance																								
<p>Deductible The deductible options listed apply per calendar year to in-network charges. Covered charges for the primary insured and covered dependents accumulate to satisfy one common, calendar-year family deductible. The family deductible must be satisfied before the selected coinsurance benefits begin.</p> <p>In-network and out-of-network deductibles accumulate separately. However, when the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.</p>	<table border="0"> <tr> <td>Individual</td> <td>Family</td> </tr> <tr> <td>D \$1,250</td> <td>\$2,500</td> </tr> <tr> <td>D \$1,500</td> <td>\$3,000</td> </tr> <tr> <td>D \$2,500</td> <td>\$5,000</td> </tr> <tr> <td>D \$2,900</td> <td>\$5,800</td> </tr> </table> <p>Out-of-network deductible: Two times the in-network deductible amount</p>	Individual	Family	D \$1,250	\$2,500	D \$1,500	\$3,000	D \$2,500	\$5,000	D \$2,900	\$5,800														
Individual	Family																								
D \$1,250	\$2,500																								
D \$1,500	\$3,000																								
D \$2,500	\$5,000																								
D \$2,900	\$5,800																								
<p>Coinsurance After the deductible has been satisfied, the plan will pay the selected coinsurance percentage of covered in-network charges.</p>	<p>D 100% (available only with the \$2,900/\$5,800 deductible) D 80% D 70% D 60%</p> <p>Out-of-network coinsurance: 70% when the 100% in-network coinsurance is selected, 60% when the 80% in-network coinsurance is selected, 50% when the 70% or 60% in-network coinsurance is selected</p>																								
<p>Coinsurance out-of-pocket maximum In addition to the deductible, the insured person is responsible for the selected out-of-pocket amount per calendar year for in-network charges.</p> <p>In-network and out-of-network out-of-pocket amounts accumulate separately. However, when the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.</p>	<p>With the 100% coinsurance: \$0</p> <p>With the 80% coinsurance:</p> <table border="0"> <tr> <td>Individual</td> <td>Family</td> </tr> <tr> <td>D \$500</td> <td>\$1,000</td> </tr> <tr> <td>D \$1,000</td> <td>\$2,000</td> </tr> <tr> <td>D \$1,500</td> <td>\$3,000</td> </tr> <tr> <td>D \$2,000</td> <td>\$4,000</td> </tr> <tr> <td>D \$3,000</td> <td>\$6,000</td> </tr> <tr> <td>D \$4,000</td> <td>\$8,000</td> </tr> </table> <p>With the 70% coinsurance:</p> <table border="0"> <tr> <td>D \$1,500</td> <td>\$3,000</td> </tr> <tr> <td>D \$2,250</td> <td>\$4,500</td> </tr> <tr> <td>D \$3,000</td> <td>\$6,000</td> </tr> </table> <p>With the 60% coinsurance:</p> <table border="0"> <tr> <td>D \$2,000</td> <td>\$4,000</td> </tr> <tr> <td>D \$3,000</td> <td>\$6,000</td> </tr> </table> <p>Out-of-network out-of-pocket: \$1,500 per individual or \$3,000 per family when the 100% coinsurance is selected; for all other coinsurance and out-of-pocket selections the out-of-network out-of-pocket is two times the in-network out-of-pocket</p>	Individual	Family	D \$500	\$1,000	D \$1,000	\$2,000	D \$1,500	\$3,000	D \$2,000	\$4,000	D \$3,000	\$6,000	D \$4,000	\$8,000	D \$1,500	\$3,000	D \$2,250	\$4,500	D \$3,000	\$6,000	D \$2,000	\$4,000	D \$3,000	\$6,000
Individual	Family																								
D \$500	\$1,000																								
D \$1,000	\$2,000																								
D \$1,500	\$3,000																								
D \$2,000	\$4,000																								
D \$3,000	\$6,000																								
D \$4,000	\$8,000																								
D \$1,500	\$3,000																								
D \$2,250	\$4,500																								
D \$3,000	\$6,000																								
D \$2,000	\$4,000																								
D \$3,000	\$6,000																								
Outpatient diagnostic lab and X-ray	Covered charges apply to deductible and coinsurance																								
Emergency room	Covered charges apply to deductible and coinsurance																								
<p>Emergency ambulance services Coverage includes ground, air and water ambulance services.</p>	Covered charges apply to deductible and coinsurance																								
Prescription drug coverage	<p>D All covered prescription drugs apply to the major medical plan deductible and coinsurance.</p> <p>D No prescription drug coverage; outpatient prescription drugs are excluded from the insurance coverage and expenses are not applied to deductible or coinsurance</p>																								

* Benefit selections must meet federal guidelines for use with a health savings account (HSA). Based on the total calendar-year out-of-pocket amount (deductible plus coinsurance out-of-pocket) certain benefit combinations are not available. The deductible and out-of-pocket amounts are subject to annual cost-of-living adjustments as may be required by federal guidelines to maintain the plan's HSA eligibility.

Additional CVCH plan benefit information

All benefits listed apply per covered person.

- ▶ **Routine mammography and cytological screening**
100%—in- and out-of-network covered charges are not subject to a plan copay, deductible or coinsurance
- ▶ **Preventive services**
Covered preventive services are those rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF) along with well-child care, routine adult physicals, prostate cancer screening, colorectal cancer screening services and annual flu shots.
In-network: 100%—covered charges are not subject to a plan copay, deductible or coinsurance
Out-of-network: no coverage
- ▶ **Inpatient and outpatient facilities, surgical services, durable medical equipment and maternity**
Subject to deductible and coinsurance
- ▶ **Outpatient physical, occupational or speech therapy**
Subject to deductible and coinsurance up to a maximum benefit of 30 treatments per calendar year for any one type of therapy and 60 treatments per calendar year for any combination of therapies
- ▶ **Mental, nervous and chemical dependency disorders**
Covered charges for all mental, nervous and chemical dependency disorders are subject to deductible and coinsurance.
Inpatient mental and nervous care: maximum benefit of 30 days per calendar year
Outpatient mental and nervous care: maximum benefit of 30 visits per calendar year
Outpatient chemical dependency care: maximum benefit of \$25 per visit
- ▶ **Organ transplant**
Covered human organ and tissue transplants include those for bone marrow, cornea, heart, heart-lung, pancreas, pancreas-kidney, kidney, liver and small bowel.
Center of Excellence provider: subject to deductible and coinsurance up to the plan’s \$5 million calendar-year maximum benefit
Non-Center of Excellence in-network provider: subject to deductible and coinsurance up to a maximum benefit of \$400,000 per transplant.
Non-Center of Excellence out-of-network provider: subject to deductible and coinsurance up to a maximum benefit of \$200,000 per transplant.
- ▶ **Non-surgical back treatment (including chiropractic care)**
Subject to deductible and coinsurance up to a maximum benefit of 20 visits per calendar year
- ▶ **Oral surgery**
Subject to deductible and coinsurance up to a maximum benefit \$5,000 per surgery
- ▶ **Skilled nursing care**
Subject to deductible and coinsurance up to a maximum benefit of 30 days per calendar year
- ▶ **Home health care**
Subject to deductible and coinsurance up to a maximum benefit of 60 visits per calendar year
- ▶ **Hospice care**
Maximum benefit of six months per calendar year
In-network: 100% after deductible
Out-of-network: subject to deductible and coinsurance

Plan information

The following provides a brief overview of the CVCH group health plan's guidelines, definitions, limitations and exclusions. This brochure is not the group policy or certificate. Please refer to the Certificate of Coverage under group policy form MNL MMP 0205 for detailed definitions along with a full explanation of plan guidelines, benefits, exclusions and limitations.

Precertification

Precertification is a screening process that uses established criteria to determine whether a proposed length and date of inpatient hospital confinement, a proposed treatment plan, or proposed services and supplies are medically necessary and appropriate. Failure to precertify an inpatient confinement will result in an additional deductible amount of \$500 per occurrence. If specified prescription drugs are not precertified, no benefits will be payable toward their cost. Precertification is not required in all states and is not a guarantee that benefits will be paid.

Pre-existing conditions

A pre-existing condition is a condition, whether physical or mental and regardless of cause, for which medical advice, diagnosis, care or treatment was received within the six-month period ending on the insured person's enrollment date. A pregnancy will not be considered a pre-existing condition. A pre-existing condition will not be covered for a period of 12 months after the enrollment date (18 months for late enrollees).

The pre-existing condition limitation period will be reduced if the insured person is not a late enrollee and has had previous, creditable coverage as defined in the Health Insurance Portability and Accountability Act. The reduction is based on the length of the time the insured was previously covered without a gap in coverage of more than 63 days.

The pre-existing condition limitation does not apply to any covered person who is under the age of 19.

Premium changes

Premiums may change during an initial rate guarantee period if: 1) the employer adds or deletes covered employees or dependents; 2) the business moves to another geographic area; 3) the employer modifies the plan benefits; or 4) benefits change due to applicable federal or state rules and regulations.

PPO network

CVCH Health Plans offer employees lower out-of-pocket costs when they utilize in-network CVCH providers. Charges resulting from emergency services received from an out-of-network provider will be considered in-network. Outside of an emergency situation, all covered charges from out-of-network providers will be paid at the out-of-network benefit level. If prior authorization is received

through CVCH's referral process then the authorized services would be paid at the in-network benefit level. If insured employees need treatment, services or supplies while traveling outside of the in-network service area, they can call the toll-free number listed on the ID card to be directed to providers in the national network. Insureds may receive a discount for these covered charges; however, benefits will be paid at the out-of-network benefits level.

Usual, Reasonable and Customary Charges

Out-of-network charges are subject to the Usual, Reasonable and Customary charge which is the usual charge the company determines to be within the range of provider fees charged for treatment, services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographical area in which the treatment, services or supplies are furnished. Charges above the Usual, Reasonable and Customary amount are not considered a covered expense.

Employee and dependent eligibility requirements

Although eligibility guidelines may vary by state, an employee actively working at least 30 hours per week may enroll for coverage. An eligible employee may also enroll her/his lawful spouse and dependent children.

Renewability of coverage

The insuring carrier may refuse to renew or modify coverage if: premiums are not paid; the employer fails to meet contribution or participation requirements; it is determined that the employer or an employee has committed fraud or has misrepresented material facts under the terms of the group policy; or the insurer elects to discontinue offering this type of group health insurance coverage, elects to discontinue all health insurance offered to any employee subject to the insurer giving the employer advanced written notice in accordance with applicable state law(s).

Termination of benefits

Coverage for an employee or insured dependent will remain in force until: the required premium is not paid; employment is terminated; the employee or dependent no longer meet the eligibility criteria established by the policy; the employee or dependent enters the armed forces; or the employer terminates the group's coverage under the policy.

Group association major medical insurance

This group medical insurance plan is available to eligible employers that elect to join the Communicating for America, Inc. association. Employers are considered to be plan administrators, as defined by ERISA, for the insurance plan they select for their employees. The association is the policyholder of this plan of insurance. Communicating for America, Inc. (CA) was established more than 35 years ago to provide benefits and services to individuals, families and small businesses. CA's mission is to promote health, well-being and the advancement of all self-employed Americans and small business owners; give members the right and opportunity to set policies and goals; and deliver valued member benefits at the best price and of the highest quality.

Major medical plan exclusions summary

The following is a partial listing of the exclusions of the CVCH group health plans. Please consult the Certificate of Coverage for a complete description of the charges, services and supplies excluded from coverage.

Except as specifically provided for in the policy, the policy does not provide any benefits for the following charges, treatment, services or supplies for, or related to:

- Treatment that is not medically necessary, is considered experimental or investigational, or is for complications of a condition not covered;
 - An act of war or participation in a riot or insurrection; act or attempt of a crime or felony;
 - Active duty with the military of any country or international organization;
 - Any over-the-counter medication or medication that may be obtained without a prescription;
 - Physical examinations, immunizations and checkups that are not medically necessary for treatment of injury or sickness, except preventive services rated with an "A" or "B" by the United States Preventive Services Task Force or services specified in the Certificate of Coverage or Wellness Benefit Rider;
 - Any injury or sickness that arises out of or in the course of any employment for wage or profit; an injury or sickness for which the employee or dependent has or had a right to recovery under any workers' compensation or occupational disease law;
 - The teeth and gums other than tumors, or any other associated structures;
 - Treatment for temporomandibular joint (TMJ) dysfunction;
 - Treatment, services or supplies for mental, nervous or chemical dependency disorders except as specified in the Certificate of Coverage;
 - Acupuncture except when used in lieu of an anesthetic; hypnosis;
 - Surgery to correct refractive errors; routine eye exams, glasses or contact lenses; or routine hearing exams or hearing aids, except those services specified in the Wellness Benefit Rider;
 - Human organ or tissue transplant expenses except as specified in the Certificate of Coverage; implant of an artificial organ;
 - Treatment for which no charge is made or for which the insured person is not required to pay; treatment rendered by a member of the insured's family;
 - Any treatment, service or supply provided by a government-owned or operated facility or government employed health care providers, unless the insured person is legally required to pay charges;
 - Any loss sustained or incurred while the insured is under the influence of any illegal narcotic or other drugs unless administered by a physician and taken in accordance with the prescribed dosage;
 - Voluntary abortion; infertility including impregnation techniques; or reversal of sterilization;
 - Attempted suicide or intentionally self-inflicted injury or sickness while sane, except if the self-inflicted injury or sickness is the result of a medical condition;
 - Obesity or weight reduction including all forms of surgery; tobacco cessation programs and products; exercise equipment; education or training materials; marriage or family counseling; sexual reassignments, dysfunctions or inadequacies;
 - Orthotics; or treatment, services or supplies related to the feet by means of posting or strapping;
 - Private-duty nursing; custodial care;
 - Treatment, services or supplies received or purchased outside the United States (unless charges are incurred while traveling on business or pleasure for no more than 90 days, and are for emergency care, and are approved for use in the United States);
 - Fees for telephone consultations, missed appointments, completing claim forms, obtaining hospital recertification or related to the provision of medical records;
 - Outpatient prescription drugs, including specialty medications, unless an optional prescription drug benefit is selected.
- When a prescription drug benefit is selected, additional exclusions and limitations apply. The following exclusion summary is a partial list. Please consult the Prescription Medication Benefit Rider for a complete description of the charges and supplies not covered.
- In addition to all of the exclusions listed above for the major medical plan, the following exclusions apply to outpatient prescription drug coverage:
- Immunization agents, biological sera, blood or blood plasma
 - Homeopathic medications
 - Medications purchased outside the United States
 - Over-the-counter medications, supplies or products
 - Medications for the treatment of hair loss or obesity

Cedar Valley Community Healthcare

Cedar Valley Community Healthcare (CVCH) is the Cedar Valley's only locally owned and managed health program. Established to provide a local option to large, national companies who dominate the health insurance market, CVCH has developed a network of providers in the area to bring you affordable health care solutions.

Madison National Life Insurance Company, Inc.

Madison National Life Insurance Company, Inc. is the insurer for the insurance benefits described in this brochure. Madison National Life, a member of The IHC Group, is rated A- (Excellent) for financial strength by A.M. Best Company Inc., a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations. (An A++ rating from A.M. Best is its highest rating.)

The IHC Group

For almost three decades member companies of The IHC Group have built a reputation of commitment to the markets they serve. With over one million customers nationwide, The IHC Group's focus is to be an innovative partner to small businesses, individuals and families.

Important information

The information included in this brochure is a summary outline of the features, plan provisions, benefits, exclusions, limitations, and other information about the medical insurance underwritten by Madison National Life Insurance Company, Inc. This brochure is not a contract and it is not intended to serve as legal interpretation of the policy. Benefits, exclusions, limitations and availability vary by state. Any provisions of the policy that are in conflict with federal laws, or any applicable state law, are amended to meet the minimum requirements of the law. For complete details, please refer to the Group Policy providing major medical expense benefits, issued to Communicating for America, Inc. association in the District of Columbia, Policy form # MNL MMP 0205.

