IDCA Limited Benefit Plan

Summary of Benefits 2021

	$25,000	$15,000
Description	**In Network Only**	**In Network Only**
Deductible Individual / Family	$2,500 per person / $4,500 family max	$2,500 per person /$4,500 family max
Maximum Out of Pocket Ind / Family	$15,000 per person / $20,000 family max	$10,000 per person / $15,000 family max
Co-Insurance Plan Pays / Your Cost	60%/40% Up to Maximum Out of Pocket Then the Plan will pay 100% up to a Maximum of $25,000 Per Year Per Person 12 month waiting period on pre-existing conditions	60%/40% Up to Maximum Out of Pocket Then the Plan will pay 100% up to a Maximum of $15,000 Per Year Per Person 12 month waiting period on pre-existing conditions
Preventive Care		
Annual Physical Exams	No Charge / Not Subject to Deductible	No Charge / Not Subject to Deductible
Well Baby/Child & Immunizations	No Charge / Not Subject to Deductible	No Charge / Not Subject to Deductible
Annual Well Woman Visits	No Charge / Not Subject to Deductible	No Charge / Not Subject to Deductible
Labs & X-rays Cancer Screenings	No Charge / Not Subject to Deductible	No Charge / Not Subject to Deductible
Colonoscopies	No Charge / Not Subject to Deductible	No Charge / Not Subject to Deductible
Physician Office Services		
Primary Care	$35.00 co-pay - $1,000 Per Year Per Person	$35.00 co-pay up to $1,000 Per Year Per Person
Urgent Care/Walk-In Clinics	$40.00 co-pay - $1,000 Per Year Per Person	$40.00 co-pay up to $1,000 Per Year Per Person
Specialist	$60.00 co-pay - $1,000 Per Year Per Person	$50.00 co-pay up to $1,000 Per Year Per Person
Other Services	Non-Emergency Visits are not covered	Non-Emergency Visits are not covered
Emergency Room Visits	Limit 1 Visit Per Year Per Person 60% after Deductible up to Annual Maximum	Limit 1 Visit Per Year Per Person 60% after Deductible up to Annual Maximum
Ambulance Services	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Allergy	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Chiropractic Services	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Lab & X-ray Services		
Lab, X-ray & diagnostics	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Major Diagnostics – CT, PET MRI, MRA, Nuclear	$1,000 Annual Benefit Per Year Per Person	$1,000 Annual Benefit Per Year Per Person
Chemo, Radiation, Renal Dialysis		
Hospital – Outpatient	No Coverage	No Coverage
Office Visit	No Coverage	No Coverage
Facility Services	Limit 2 Visits Per Year Per Person	Limit 2 Visits Per Year Per Person
Inpatient Facility	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Outpatient Facility	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Skilled Nursing Facility	No Coverage	No Coverage
Medical Equip & Home Health	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Outpatient Rehab Therapy		
Physical, Occ, Speech, & Cardiac	No Coverage	No Coverage
Mental Health & Substance Abuse		
Inpatient Services	No Coverage	No Coverage
Outpatient Services	No Coverage	No Coverage
Office Visits	60% after Deductible up to Annual Maximum	60% after Deductible up to Annual Maximum
Prescription Services	$1,200 Maximum Pharmacy Benefit Per Year Per Person	$1,200 Maximum Pharmacy Benefit Per Year Per Person
Generic & Preferred Generic	$10.00 / up to max pharmacy benefit	$10.00 / up to max pharmacy benefit
Branded Drugs	Not Covered	Not Covered
Specialty Drugs	Not Covered No Injectable except for “Insulin Diabetic Medications”	Not Covered No Injectable except for “Insulin Diabetic Medications”

*** This is not a complete summary of benefits; please refer to the schedule of benefits for more detailed plan options and limitations.*