Iowa Stopgap Measure Payment Summary

This chart summarizes payment responsibilities under the Iowa Stopgap Measure. It is only intended to provide an overview. Please see the carrier's policy form for additional information.

Consumer Pays...
Deductible **$7,350** per person. **$14,700** (maximum) per family.
Advanced Imaging Copayment **$400** for covered CT (computerized tomography), MRAs (magnetic resonance angiography), MRIs (magnetic resonance imaging), and PET (positron emission tomography) received from any Network Provider
Emergency Room Copayment **$400** (waived if admitted)
Office Visit Copayment **$35** for: ■ covered services received from Network primary care providers ■ covered services received from Network chiropractors ■ covered services received from Network occupational therapists ■ covered services received from Network physical therapists ■ covered services received from Network speech pathologists ■ covered mental health and chemical dependency treatment received in an office setting from any Network Provider ■ independent labs **$70** for covered services received from Network non-primary care providers
Other Copayment ■ covered occupational therapy, physical therapy, and speech therapy received in an outpatient setting from any Network Provider. ■ covered ultrasounds and labs and x-rays received in an outpatient or home health setting from any Network Provider.
Telehealth Services Copayment **$35** for covered telehealth services received from contracting telehealth practitioners.
Prescription Drugs Copayment **$10** for Tier 1 medications. **$50** for Tier 2 medications. **$150** for Tier 3 medications. **$200** for preferred specialty drugs. **$300** for non-preferred specialty drugs.
Medical Coinsurance **20%** for prosthetic limb devices
Pediatric Vision Cost Share This plan pays for the first $130 of the covered charges for non-medically necessary contact lenses. You are responsible for 85% of covered charges in excess of the $130. This plan pays for the first $130 of covered charges for frames. You are responsible for 80% of covered charges in excess of the $130. This plan pays for two spectacle lenses per benefit year. The lens coverage includes single vision, bifocal, trifocal, lenticular, polycarbonate as well as scratch-resistant coating, tinting, and ultraviolet protective coating. For anything beyond these lens options the member is responsible for 80% of the cost.
Preventive Health Services No cost for services required by the Affordable care Act when received from a Network Provider
Out-of-Pocket Maximum **$7,350** per person. **$14,700** (maximum) per family.