Heart of America Health Plan "Low Option Plan"

NO Annual Deductibles!! DESCRIPTION OF BENEFITS	COPAYMENT AMOUNT YOU PAY	HAHP BENEFIT AMOUNT	EXCEPTIONS/LIMITATIONS
Preventive Health Services			No maximum benefit allowance.
Routine childhood and adult immunizations.	$0	100%	
Routine physicals including prostate & breast exams, Gynecology exams, and other preventive health services.	**$15**	100%	
(See Diagnostic Services below for Mammograms, Pap smears & PSA's)			
Physician Services			
Hospital visits, including inpatient and skilled nursing facility visits.	$0	100%	
Office visits and/or house calls authorized by PCP.	**$15**	100%	
Specialist consultation and treatment when authorized by PCP.	**$25**	100%	
Diagnostic / Therapeutic Services			20% Coinsurance will be applied to readings & interpretations for these services billed by an outside facility.
Pap smears, Mammograms, PSA's, X-Rays, CT scans, MRI's, EKG's, Lab tests, Chemotherapy, Radiation, & other medically necessary services.	$0	100%	
Inpatient Hospital Services			
Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services.	**$250 (1st/4th Day)**	100%	$1,000 copay maximum per contract per calendar year
Outpatient Hospital Services at Heart of America Med. Center.	$0	100%	
Maternity Services			
Prenatal care.	**$15**	100%	$15 copay on first visit. Then 100% covered.
Hospital services, Birthing/delivery, & Newborn nursery.	**$250 (1st/4th day)**	100%	$1,000 copay max per calender year
Well-baby care.	**$15**	100%	Until 24 months old.
Emergency Services			
Emergency room, Physician/Nursing services, & Ambulance services.	**$30**	100%	In or Out of Area Emergencies.
Mental Health Services			
Inpatient &/or Partial hospitalization.	**$250 (1st/4th day)**	100%	Inpatient Max: 45 days per calendar year.
Outpatient.		100%/80%	Outpatient: 100% hours 1-5; hours 6-30 80%
Residential Treatment	**$250 (1st/4th day)**	100%	Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services			
Inpatient &/or Partial hospitalization.	**$250**	100%	Inpatient Max: 60 days per calendar year.
Outpatient.		100%/80%	Outpatient: 100% visits 1-5; visits 6-20 80%
Referral Services			
Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list.	**$25**	80%	$500 coinsurance max. per calendar year
Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services can NOT be provided by participating providers.	**$25**	80%	$500 coinsurance max. per calendar year
Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services CAN be provided by participating providers.	**$25**	80%	With prior authorization by PCP and HAHP. $3,000 coinsurance max. per calendar year
Chiropractic Care	**$10**	80%	With prior approval by PCP and HAHP.
Physical, Speech, and Occupational Therapy	**$10**	Short-term therapy is 1st two consecutive months. Long-term therapy is one PT and one OT visit/month following short term	
Durable Medical Equipment Orthopaedic and Prosthetic Devices.	80% coverage on items exceeding $25. Coinsurance max. payable by the member is $500/contract/year. Maximum benefit is $3,500/member/year.		
Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.	100% coverage when authorized by primary care physician. (Up to 60 days per calendar year)		
CMJ (Craniomandibular joint disorder) TMJ (Temporomandibular joint disorder)	Lifetime maximum of $10,000 surgical, $2,500 non-surgical/member.		
Home Health Nursing Care	100% coverage when authorized by primary care physician.		
Hospice Services	Covered in accordance with Medicare Guidelines.		

This sheet describes the essential features of the HAHP in general terms and is not intended to be a full description.