

Heart of America Health Plan "Share Option Plan"

| Deductibles= SNG-\$500 SPD-\$750 FAM-\$1000 Coinsurance Max/Yr= SNG-\$1000 SPD-\$1500 FAM-\$2000 | COPAYMENT AMOUNT YOU PAY | BENEFIT AFTER DEDUCT. | EXCEPTIONS/LIMITATIONS |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| DESCRIPTION OF BENEFITS | | | |
| Preventive Health Services (By Primary Care Physician) Routine childhood and adult immunizations. Routine physical exam including Prostate & Breast exams, Gynecological exams, and other preventive health services. | \$0 \$15 | 100% 100% | No maximum benefit allowance. Deductible Waived |
| Physician Services (By Primary Care Physician) Hospital visits, including inpatient and skilled nursing facility visits. Office visits and/or house calls authorized by PCP. | \$0 \$15 | 100% 100% | Deductible Waived |
| Diagnostic Services Mammograms, Pap smears, PSA's, X-Rays, CT scans, MRI's, EKG's, Lab Tests & other medically necessary services provided at HAMC or other facility | \$0 | 80% | Deductible Applies |
| Chemotherapy & Radiation Therapy Services provided at JCPC Services provided at HAMC or contracted Referral Facility | \$0 \$0 | 100% 80% | Deductible Waived Deductible Applies |
| Inpatient Hospital Services Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services. | \$0 | 80% | |
| Outpatient Hospital Services <i>at Heart of America Medical Center or Referral Facility</i> | \$0 | 80% | |
| Maternity Services Prenatal care (at JCPC) Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care (at JCPC) | \$15 \$0 \$15 | 100% 80% 100% | \$15 copay on first visit. Then 100% covered. Deductible applies Until 24 months old. Deductible Waived. |
| Emergency Services Emergency room, Physician/Nursing services. | \$30 | 80% | In or Out of Area Emergencies. |
| Ambulance Services | \$0 | 80% | When medically necessary |
| Mental Health Services Inpatient &/or Partial hospitalization. Outpatient. Residential Treatment | \$0 \$0 \$0 | 80% 80% 80% | Inpatient Max: 45 days per calendar year. 100% hours 1-5; (hours 6-30 80% after deductible) Up to 120 days per member per calendar year |
| Alcohol and Substance Abuse Services Inpatient &/or Partial hospitalization. Outpatient. | \$0 \$0 | 80% 80% | Inpatient Max: 60 days per calendar year. 100% visits 1-5;(visits 6-20; 80% after deduct.) |
| Referral Services Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list. 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. 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 \$25 \$25 | 80% 80% 60% | With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP |
| Chiropractic Care | \$10 | 80% | With prior approval by PCP and HAHP |
| Physical, Speech, and Occupational Therapy Outpatient | \$10 | 80% | Short-term therapy: 1st two consecutive months Long-term therapy: one PT/ one OT visit/month |
| Durable Medical Equipment Orthopaedic and Prosthetic Devices. | \$0 | 80% | \$2,000 Maximum Benefit per member/year. |
| Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility. | \$0 | 80% | When authorized by primary care physician. (up to 60 days per calendar year) |
| TMJ/CMJ (Temporomandibular/Craniomandibular joint disorder) | \$0 | 80% | Lifetime max. of \$10,000 surg./\$2,500 non-surg. |
| Home Health Nursing Care | \$0 | 80% | when authorized by primary care physician. |
| Hospice Services | \$0 | 80% | Covered in accordance with Medicare Guidelines. |

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