

Heart of America Health Plan

"High Option Plan"

NO Annual Deductibles!!	COPAYMENT	HAHP	EXCEPTIONS/LIMITATIONS
DESCRIPTION OF BENEFITS	AMOUNT YOU PAY	BENEFIT AMOUNT	
Preventive Health Services Routine childhood and adult immunizations. Routine physicals, Gynecological exams, Prostate screenings, Mammograms, Pap smears, and other preventive health services.	\$0 \$15	100% 100%	No maximum benefit allowance.
Physician Services Hospital visits, including inpatient and skilled nursing facility visits. Office visits and/or house calls authorized by PCP. Specialist consultation and treatment when authorized by PCP.	\$0 \$15 \$25	100% 100% 100%	
Diagnostic / Therapeutic Services X-Rays, CT scans, MRI, Electrocardiograms, Laboratory 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.	\$0	100%	
Outpatient Hospital Services at Heart of America Med. Center.	\$0	100%	
Maternity Services Prenatal care. Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care.	\$15 \$0 \$15	100% 100% 100%	\$15 copay on first visit. Then 100% covered. 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. Outpatient Residential Treatment	\$0 \$0	100% 100%/80% 100%	Inpatient Max: 45 days per calendar year. Outpatient: 100% hours 1-5; hours 6-30 80% Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services Inpatient &/or Partial hospitalization. Outpatient.	\$0	100% 100%/80%	Inpatient Max: 60 days per calendar year. 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. 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	100% 100% 80%	With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP \$5,000 coinsurance maximum per contract per calendar year.
Chiropractic Care	\$10	100%	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)
TMJ (Temporomandibular joint disorder) CMJ (Craniomandibular 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 plan in general terms and is not intended to be a full description.