

# ***Heart of America Health Plan "High Option Plan"***

NO Annual Deductibles!!	COPAYMENT AMOUNT YOU PAY	HAHP BENEFIT AMOUNT	EXCEPTIONS/LIMITATIONS
DESCRIPTION OF BENEFITS			
<b>Preventive Health Services</b> Routine childhood and adult immunizations. Routine physicals, Gynecological exams, Prostate and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	\$0 \$0	100% 100%	No maximum benefit allowance.
<b>Physician Services</b> 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%	
<b>Diagnostic / Therapeutic Services</b> X-Rays, CT scans, MRI's, EKG's, Laboratory Tests, Chemotherapy, Radiation, & other medically necessary services.	\$0	100%	
<b>Inpatient Hospital Services</b> Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services.	\$0	100%	
<b>Outpatient Hospital Services at Primary Care Hospital</b>	\$0	100%	
<b>Maternity Services</b> Prenatal care. Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care.	\$15 \$0 \$0	100% 100% 100%	\$15 copay on first visit. Then 100% covered.
<b>Emergency Services</b> Emergency room, Physician/Nursing services, & Ambulance services.	\$30	100%	In or Out of Area Emergencies.
<b>Mental Health Services</b> 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
<b>Alcohol and Substance Abuse Services</b> 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%
<b>Referral Services</b> 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 \$3,000 coinsurance maximum per contract per calendar year.
<b>Chiropractic Care</b>	\$10	100%	With prior approval by PCP and HAHP
<b>Physical, Speech, and Occupational Therapy</b>	\$10		Short-term therapy is 1st two consecutive months. Long-term therapy is one PT and one OT visit/month following short term.
<b>Durable Medical Equipment</b> 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.
<b>Skilled Nursing Facility</b> 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)
<b>TMJ (Temporomandibular joint disorder)</b> <b>CMJ (Cranio-mandibular joint disorder)</b>			Lifetime maximum of \$10,000 surgical, \$2,500 non-surgical/member.
<b>Home Health Nursing Care</b>			100% coverage when authorized by primary care physician.
<b>Hospice Services</b>			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.			
<b>* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.</b>			