

Heart of America Health Plan

"Low 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 and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	\$0 \$0	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 at Primary Care Hosp. X-Rays, CT scans, MRI's, EKG's, Lab tests, Chemotherapy, Radiation, & other medically necessary services.	\$0	100%	20% Coinsurance will be applied to readings & interpretations for these services billed by an outside facility.
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 Primary Care Hospital	\$0	100%	
Maternity Services Prenatal care. Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care.	\$15 \$250 (1st/4th day) \$0	100% 100% 100%	\$15 copay on first visit. Then 100% covered. \$1,000 copay max per calendar year
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	\$250 (1st/4th day) \$250 (1st/4th day)	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.	\$250	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	80% 80% 80%	\$500 coinsurance max. per calendar year \$500 coinsurance max. per calendar year 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 plan in general terms and is not intended to be a full description.			
* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.			

