

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 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. 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 X-Rays, CT scans, MRI's, EKG's, Lab Tests and other medically necessary services provided at Primary Care hospital or other facility.	\$0	80%	
Chemotherapy & Radiation Therapy Services provided at Primary Care Clinic Services provided at Primary Care Hosp.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 at Primary Care Hospital or Referral Facility	\$0	80%	
Maternity Services Prenatal care (at Primary Care Clinic) Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care (at Primary Care Clinic)	\$15 \$0 \$0	100% 80% 100%	\$15 copay on first visit. Then 100% covered. Deductible applies 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.			
* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.			