

# Heart of America Health Plan

# "Preferred Option Plan"

Coinsurance Max/Yr= SNG-\$1000 SPD-\$1500 SPS-\$1500 FAM-\$2000	COPAYMENT	BENEFIT	EXCEPTIONS/LIMITATIONS Ded. = SNG-\$500 SPD-\$750 SPS-\$750 FAM-\$1000
(MINOT) DESCRIPTION OF BENEFITS	AMOUNT YOU PAY	AFTER DEDUCT	
<b>Physician Services</b>			
Primary Care Physician office visits (By Trinity PCP)	\$20	100%	Deductible Waived
Convenience Care Clinic visits	\$20	80%	Deductible Applies
Other PCP Physician Services ie: Clinical procedures, Surgical services, Hospital visits, including inpatient and skilled nursing facility	\$0	80%	Deductible Applies
Referral Physician visits when authorized by PCP (see below)	\$20	80%	Deductible Applies
<b>Preventive Health Screening Services (By Trinity Hospital)</b>			
Mammograms, Pap smears, and Prostate screenings	\$0	100%	Deductible Waived
<b>Diagnostic Services</b>			
X-Rays, CT Scans, MRI's, EKG's, Lab Tests, Readings/Interpretations of Mammo, Pap, PSA screenings & other medically necessary services.	\$0	80%	Deductible Applies
<b>Chemotherapy &amp; Radiation Therapy</b>			
Services provided at Trinity Cancercare Center	\$0	80%	Deductible Applies
<b>Inpatient Hospital Services</b>			
Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically necessary services.	\$0	80%	Deductible Applies
<b>Outpatient Hospital Services</b>			
by Trinity Medical Group or Referral Facility	\$0	80%	Deductible Applies
<b>Maternity Services</b>			
Prenatal care office visits (By Trinity PCP)	\$20	100%	Deductible Waived
Diagnostic, Lab, Hospital services, Birthing/delivery, Newborn nursery.	\$0	80%	Deductible Applies
Well-baby care (By Trinity PCP)	\$20	100%	Ded. Waived on routine Immunizations & Office visits
<b>Emergency Services</b>			
Emergency room, Physician/Nursing services	\$30	80%	In or Out of Area Emergencies.
<b>Ambulance Services</b>			
	\$0	80%	When medically necessary
<b>Mental Health Services</b>			
Inpatient &/or Partial hospitalization	\$0	80%	Inpatient Max: 45 days per calendar year.
Residential Treatment	\$0	80%	Up to 120 days per calendar year.
Outpatient	\$0	80%	100% hours 1-5;(hours 6-30;80% after deduct.)
<b>Alcohol and Substance Abuse Services</b>			
Inpatient &/or Partial hospitalization.	\$0	80%	Inpatient Max: 60 days per calendar year.
Outpatient.	\$0	80%	100% visits 1-5;(visits 6-20; 80% after deduct.)
<b>Referral Services</b>			
Authorized referral to a specialty physician within the Trinity Medical Group	\$20	80%	With prior authorization by PCP and HAHP Copay applies to office visits / Consultations
Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list.	\$20	80%	With prior authorization by PCP and HAHP Copay applies to office visits / Consultations
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.	\$20	80%	With prior authorization by PCP and HAHP Copay applies to office visits / Consultations
Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services CAN be provided by participating providers.	\$20	60%	With prior authorization by PCP and HAHP. Copay applies to office visits / Consultations
<b>Chiropractic Care</b>	\$10	80%	With prior approval by PCP and HAHP.
<b>Physical, Speech, and Occupational Therapy</b>	\$10	80%	Short-term therapy: 1st two consecutive months
	\$10	80%	Long-term therapy: one PT/ one OT visit/month
<b>Durable Medical Equipment</b>			
Orthopaedic and Prosthetic Devices.	\$0	80%	\$2,000 Maximum Benefit per contract year.
<b>Skilled Nursing Facility</b>			
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)
<b>TMJ (temporomandibular joint disorder)</b>			
<b>CMJ (craniomandibular joint disorder)</b>	\$0	80%	Lifetime max. of \$10,000 surg./\$2,500 non-surg.
<b>Home Health Nursing Care</b>			
	\$0	80%	When authorized by primary care physician.
<b>Hospice Services</b>			
	\$0	80%	Covered in accordance with Medicare Guidelines.

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