

# ***Heart of America Health Plan - MINOT***

Description of Benefits	HAHP Benefit Amount	"Assurance Option Plan"
		COPAYMENT AMOUNT YOU PAY
<b>Preventive Health Services</b>		
Routine immunizations	100%	\$0
Routine Physicals, Gynecological Exams, Prostate Exams, Mammograms, Pap Smears and other preventive services.	100%	\$20 -- No Maximum Benefit Allowance --
<b>Clinic Services</b>		
Office visits and Convenience Care Clinic visits.	100%	\$20 -- Includes Physician Services --
<b>Diagnostic / Therapeutic Services</b>		
X-rays, CT scans, MRI, Electrocardiograms, Lab Tests, Chemotherapy & other medically necessary services.	100%	\$0
<b>Inpatient Hospital Services</b>		
Semi-private Room, Physician Services, General Nursing, Surgery, ICU, & other medically necessary services.	100%	\$500 (Max: \$1000/yr)
<b>Outpatient Surgery</b>		
In-Hospital or Out-Patient facility	100%	\$500 (Max: \$1000/yr)
<b>Maternity Services</b>		
Prenatal Care (copay on first visit only)	100%	\$20
Hospital services, Birthing/delivery, & Newborn nursery.	100%	\$500
Well-baby Care (Until 24 months old)	100%	\$20
<b>Emergency Services</b>		
Emergency room, Physician/Nursing services, and Ambulance services (In or Out-of-Area Emergencies).	100%	\$75
<b>Referral Services</b>		
With prior authorization by primary care physician, medically necessary services provided by Participating Providers.	100%	\$20
With prior approval by the HAHP Medical Director, medically necessary services provided by NON-Participating Providers when medical conditions require services that CANNOT be provided by Participating Providers.	100%	\$20
With Prior approval by the HAHP Medical Director, medically necessary services provided by NON-Participating Providers that CAN be provided by Participating Providers.	70%	30%
<b>Chiropractic Care</b>		
With prior approval by HAHP Medical Director.	100%	\$20
<b>Alcohol and Substance Abuse Services</b>		
Inpatient/Partial Hospitalization	100%	\$500 -- 60 Days Per Calendar Year Maximum --
Outpatient (100% for visits 1-5; 80% for visits 6-20)		
<b>Mental Health Services</b>		
Inpatient/Partial Hospitalization	100%	\$500 Inpatient Max: 45 Days per calendar year Up to 120 Days Per Calendar Year
Residential Treatment		
Outpatient (100% for hours 1-5; 80% for hours 6-30)		
<b>Physical, Speech, and Occupational Therapy</b>		
Short-term therapy	100% coverage for two consecutive months.	\$10
Long-Term therapy	100% for one PT and one OT per month.	
<b>Durable Medical Equipment</b>		
Orthopaedic and Prosthetic Devices	80% coverage on items exceeding \$25. Maximum benefit allowance of \$5000/member/calendar year.	
<b>Skilled Nursing Facility</b>		
Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.	100% for 60 Days	
<b>TMJ/CMJ</b>		
(Temporomandibular/Craniomandibular joint disorder)	Lifetime maximum of \$10,000 surgical treatment and \$2,500 nonsurgical treatment per member.	
<b>Home Health Nursing Care</b>		
	100% covered when authorized by plan physician.	
<b>Hospice Services</b>		
	Covered in accordance with Medicare Guidelines.	
<b>Maximum Annual Out-of-Pocket Expense</b>		
	200% of annual premium.	
This brochure describes the essential features of the HAHP in general terms and is not intended to be a full description.		