

# ***Heart of America Health Plan-MINOT "Assurance Option Plan"***

**NO Annual Deductibles** <b>Description of Benefits</b>	<b>HAHP Benefit Amount</b>	<b>COPAYMENT AMOUNT YOU PAY</b>
<b>Preventive Health Services</b> Routine child & adult immunizations Routine Physicals, Gynecological Exams, Prostate & Breast exams, Mammograms, Pap Smears, PSA's and other preventive services.*	100% 100%	\$0 \$0  -- No Maximum Benefit Allowance --
<b>Clinic Services</b> (Includes Physician Services) Office visits and Convenience Care Clinic visits.	100%	\$20
<b>Diagnostic / Therapeutic Services</b> X-rays, CT scans, MRI's, EKG's, Lab Tests, Radiation, 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 Outpatient facility	100%	(Max: \$1000/yr) \$500
<b>Maternity Services</b> Prenatal Care (copay on first visit only) Hospital services, Birthing/delivery, & Newborn nursery. Well-baby Care	100% 100% 100%	\$20 \$500 \$0
<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. 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. With Prior approval by the HAHP Medical Director, medically necessary services provided by NON-Participating Providers that CAN be provided by Participating Providers.	100% 100% 70%	\$20 \$20 \$20 & 30%
<b>Chiropractic Care</b> With prior approval by HAHP Medical Director.	100%	\$20
<b>Alcohol and Substance Abuse Services</b> Inpatient/Partial Hospitalization (60 Days max/calendar yr) Outpatient (100% for visits 1-5; 80% for visits 6-20)	100%	\$500 100% for visits 1-5; 80% for visits 6-20
<b>Mental Health Services</b> Inpatient/Partial Hospitalization Residential Treatment Outpatient	100%	\$500 - Inpatient Max: 45 days per calendar year Up to 120 Days Per Calendar Year 100% for hours 1-5; 80% for hours 6-30
<b>Physical, Speech, and Occupational Therapy</b> Short-term therapy Long-Term therapy		\$10
<b>Durable Medical Equipment</b> Orthopaedic and Prosthetic Devices		100% coverage for two consecutive months. 100% for one PT and one OT per month.
<b>Skilled Nursing Facility</b> Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.		80% coverage on items exceeding \$25. Maximum benefit allowance of \$5000/member/calendar year.
<b>TMJ/CMJ</b> (Temporomandibular/Craniomandibular joint disorder)		100% for 60 Days
<b>Home Health Nursing Care</b>		Lifetime maximum of \$10,000 surgical treatment and \$2,500 nonsurgical treatment per member.
<b>Hospice Services</b>		100% covered when authorized by plan physician. 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>		