

Heart of America Health Plan - MINOT "Elite Option Plan"

NO Annual Deductibles Description of Benefits	HAHP Benefit Amount	COPAYMENT AMOUNT YOU PAY
Preventive Health Services Routine adult & child 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 --
Clinic Services Office visits and Convenience Care Clinic visits.	100%	--Includes Physician Services-- \$20
Diagnostic / Therapeutic Services X-rays, CT scans, MRI's, EKG's, Lab Tests, Radiation, Chemotherapy & other medically necessary services.	100%	\$0
Inpatient Hospital Services Semi-private Room, Physician Services, General Nursing, Surgery, ICU, & other medically necessary services.	100%	\$0
Outpatient Surgery In Hospital or Outpatient facility	100%	\$0
Maternity Services Prenatal Care (copay on first visit only) Hospital services, Birthing/delivery, & Newborn nursery. Well-baby Care	100% 100% 100%	\$20 \$0 \$0
Emergency Services Emergency room, Physician/Nursing services, and Ambulance services (In or Out-of-Area Emergencies).	100%	\$30
Referral Services 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 and 30%
Chiropractic Care With prior approval by HAHP Medical Director.	100%	\$10
Alcohol and Substance Abuse Services Inpatient/Partial Hospitalization (60 Days max/calendar year) Outpatient (100% for visits 1-5; 80% for visits 6-20)	100%	\$0
Mental Health Services Inpatient/Partial Hospitalization Residential Treatment Outpatient	100%	\$0 Inpatient Max: 45 Days per calendar year Up to 120 Days Per Calendar Year 100% for hours 1-5; 80% for hours 6-30
Physical, Speech, and Occupational Therapy Short-term therapy Long-Term therapy		\$10 100% coverage for two consecutive months. 100% for one PT and one OT per month.
Durable Medical Equipment Orthopaedic and Prosthetic Devices		80% coverage on items exceeding \$25. Maximum benefit allowance of \$5000/member/calendar year.
Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.		100% for 60 Days
TMJ/CMJ (Temporomandibular/Craniomandibular joint disorder)		Lifetime maximum of \$10,000 surgical treatment and \$2,500 nonsurgical treatment per member.
Home Health Nursing Care		100% covered when authorized by plan 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.		

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