

Avera MyPlan

Health care benefits for individuals

Benefit Summary - MyPlan #4

Benefits	In Network	Out of Network
Deductibles		
Individual	\$2,000*	\$5,000*
Family	\$4,000*	\$10,000*
Coinsurance	60%	60%
Out of Pocket Maximum (Includes medical deductible and coinsurance)		
Individual	\$4,000	No Maximum Limit
Family	\$8,000	No Maximum Limit
Maximum Lifetime Benefit		\$2 Million
Medical Office Visit		
Office Visit Copay includes limited Lab and X-ray Services; see Office Visit with Lab & X-ray Option insert in the Policy		
Primary and Specialist Care	\$25 copay (5 visit limit per member; deductible and coinsurance follow)	60% after deductible
Preventive Health Services (With any participating Physician, PA, or NP)		
Well Child (Office Visit Only)	\$25 copay	No Coverage
Annual Physical Exam 1 per calendar year (Office Visit Only)	\$25 copay	No Coverage
Well Woman 1 per year (Including pap smear, hemoglobin and urinalysis)	\$25 copay	No Coverage
Routine Immunizations	100%	No Coverage
Screening Mammogram (1 baseline age 35-39; Annual after age 40)	100%	No Coverage
PSA Screening (Annual if history of prostate cancer, age 45-49 at high risk or for age 50 and over)	100%	No Coverage
Colorectal (fecal occult only, 1 per calendar year) age 50 and over	100%	No Coverage
Lipid Screening (1 every 5 years)	100%	No Coverage
Glucose Screening (1 every 3 years)	100%	No Coverage
Emergency Services	60% after deductible	60% after deductible
Laboratory and X-Ray Services	60% after deductible	60% after deductible
Inpatient Hospital Services	60% after deductible	60% after deductible
Inpatient Rehabilitative Services (30 day maximum per calendar year)		
Inpatient Physician Services and Consultations	60% after deductible	60% after deductible
Outpatient Hospital Services	60% after deductible	60% after deductible
Outpatient Surgery	60% after deductible	60% after deductible
Home Health Care (1 visit is a maximum of 4 hours) (60 visit maximum per calendar year)	60% after deductible	60% after deductible

Benefits	In Network	Out of Network
Hospice Care		
Inpatient	60% after deductible	60% after deductible
Outpatient (Combined inpatient and outpatient 185 day maximum benefit while covered under plan)	60% after deductible	60% after deductible
Skilled Nursing Facility Service	60% after deductible 100 days/confinement max	60% after deductible 60 days/confinement max
Same confinement if readmitted with same diagnosis within 60 days		
Ambulance and Other Transportation Services	60% after deductible	60% after deductible
Mental Health Services		
Inpatient	60% after deductible	60% after deductible
Outpatient (20 visit maximum per calendar year)	60% after deductible	60% after deductible
Alcohol Dependency Treatment Services		
Inpatient (30 day max/6 month period and 90 day maximum benefit while covered under plan)	60% after deductible	60% after deductible
Outpatient (30 visit max/6month period and 90 day maximum benefit while covered under plan)	60% after deductible	60% after deductible
Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	60% after deductible	60% after deductible
Chemical Dependency Treatment Services		
Inpatient (30 day max/6 month period and 90 day maximum benefit while covered under plan)	60% after deductible	60% after deductible
Outpatient (30 visit max/6month period and 90 day maximum benefit while covered under plan)	60% after deductible	60% after deductible
Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	60% after deductible	60% after deductible
Durable Medical Equipment (\$1,000 paid maximum per calendar year)	60% after deductible	60% after deductible
Orthopedic and Prosthetic Devices	60% after deductible	60% after deductible
Outpatient Rehabilitative Therapy includes PT, OT, and ST (20 visit limit for each per calendar year)	60% after deductible	60% after deductible
Outpatient Cardiac Rehabilitation-Phase II (20 visit maximum per calendar year)	60% after deductible	60% after deductible
Transplant Services	60% after deductible	No Coverage
Chiropractic Office Visit (20 visit maximum per calendar year)	\$25 copay (3 visit limit; deductible and coinsurance follow)	No Coverage
Prescription Drugs (3x copay for 90-day supply)		
Generic	\$10 copay applies (deductible and coinsurance waived)	No Coverage
Deductible - Individual	\$500*	No Coverage
Family	\$1,000*	No Coverage
Brand Name	80% after Rx deductible	No Coverage
Maximum Calendar Year Benefit - Individual	\$5,000	
Family	\$10,000	No Coverage

*In Network, Out of Network and Pharmacy Deductibles are separate.

Note: This document is a summary of coverage. Please refer to the policy for actual benefits and exclusions.