

Avera MyPlan

Health care benefits for individuals

Benefit Summary - MyPlan #2

Benefits	In Network	Out of Network
First Dollar Coverage	Avera Health Plans will pay the first \$500 on any covered medical expense per calendar year followed by the appropriate deductible and coinsurance. Pharmacy not included.	No Coverage
Deductibles		
Individual	\$3,000*	\$5,000*
Family	\$6,000*	\$10,000*
Coinsurance	80%	60%
Out of Pocket Maximum (Includes medical deductible and coinsurance)		
Individual	\$7,000	No Maximum Limit
Family	\$14,000	No Maximum Limit
Maximum Lifetime Benefit	\$2 Million	
Medical Office Visit		
Primary and Specialty Care	80% after deductible	60% after deductible
Preventive Health Services (With any participating Physician, PA, or NP)		
Well Child (Office Visit Only)	80% after deductible	No Coverage
Annual Physical Exam 1 per calendar year (Office Visit Only)	80% after deductible	No Coverage
Well Woman 1 per calendar year (Including pap smear, hemoglobin and urinalysis)	80% after deductible	No Coverage
Routine Immunizations	80% after deductible	No Coverage
Screening Mammogram (1 baseline age 35-39; Annual after age 40)	80% after deductible	No Coverage
PSA Screening (Annual if history of prostate cancer, age 45-49 at high risk or starting at age 50)	80% after deductible	No Coverage
Colorectal (fecal occult only, 1 per calendar year) age 50 and over	80% after deductible	No Coverage
Lipid Screening (1 every 5 years)	80% after deductible	No Coverage
Glucose Screening (1 every 3 years)	80% after deductible	No Coverage
Emergency Services	80% after deductible	80% after deductible
Laboratory and X-ray Services	80% after deductible	60% after deductible
Inpatient Hospital Services	80% after deductible	60% after deductible
Inpatient Rehabilitative Services (30-day maximum per calendar year)		
Inpatient Physician Services and Consultations	80% after deductible	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible

Benefits	In Network	Out of Network
Home Health Care (1 visit is a maximum of 4 hours) (60-visit maximum per calendar year)	80% after deductible	60% after deductible
Hospice Care Inpatient Outpatient (Combined inpatient and outpatient 185-day maximum benefit while covered under plan)	80% after deductible 80% after deductible	60% after deductible 60% after deductible
Skilled Nursing Facility Service Same confinement if readmitted with same diagnosis within 60-days	80% after deductible 100 days/confinement max	60% after deductible 60 days/confinement max
Ambulance and Other Transportation Services	80% after deductible	80% after deductible
Mental Health Services Inpatient Outpatient (20-visit maximum per calendar year)	80% after deductible 80% after deductible	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) Outpatient (30-visit max/6-month period and 90-day maximum benefit while covered under plan) Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	80% after deductible 80% after deductible 80% after deductible	60% after deductible 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) Outpatient (30-visit max/6-month period and 90-day maximum benefit while covered under plan) Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible
Durable Medical Equipment (\$1,000 paid maximum per calendar year)	80% after deductible	60% after deductible
Orthopedic and Prosthetic Devices	80% after deductible	60% after deductible
Outpatient Rehabilitative Therapy includes PT, OT, and ST (20-visit limit for each per calendar year)	80% after deductible	60% after deductible
Outpatient Cardiac Rehabilitation-Phase II (20-visit maximum per calendar year)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	No Coverage
Chiropractic Office Visit (20-visit maximum per calendar year)	80% after deductible	No Coverage
Prescription Drugs (3x copay for 90-day supply) Generic Deductible - Individual Family Brand Name	\$10 copay applies (deductible and coinsurance waived) \$500* \$1,000* 80% after Rx deductible	No Coverage No Coverage No Coverage No Coverage

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

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