

Avera MyPlan

Health care benefits for individuals

Benefit Summary - MyPlan HSA Qualified

Benefits	In Network	Out of Network
Deductibles		
Individual	\$2,500*	\$5,000*
Family	\$5,000*	\$10,000*
Coinsurance	80%	60%
Out of Pocket Max (Includes medical deductible and coinsurance)		
Individual	\$5,000	No Maximum Limit
Family	\$10,000	No Maximum Limit
Maximum Lifetime Benefit		\$2 Million
Medical Office Visit		
Primary and Specialist 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 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 for age 50 and over)	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 & 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 & Consultations	80% after deductible	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Home Health Care (1 visit is a maximum of 4 hrs) (60 visit maximum per calendar year)	80% after deductible	60% after deductible
Hospice Care		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
(Combined inpatient & outpatient 185 day maximum benefit while covered under plan)		

Benefits	In Network	Out of Network
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 & 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/6month period and 90 day maximum benefit while covered under plan) Partial Day Program (equivalent to 1/2 day & 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/6month period and 90 day maximum benefit while covered under plan) Partial Day Program (equivalent to 1/2 day & 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 & Prosthetic Devices	80% after deductible	60% after deductible
Outpatient Rehabilitative Therapy includes PT, OT, & 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 (30-day or 90-day supply)	80% after deductible	No Coverage

*In Network and Out of Network Deductibles are separate.

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

Avera *MyPlan*

Preventive Services Benefit Option

You have purchased this Benefit Option as an additional benefit to your Avera *MyPlan* Health Benefits Policy. This Policy is now amended to include the benefits provided by this Benefit Option.

The effective date for this Benefit Option is stated on the Acceptance Letter that is included with this document.

This Benefit Option is in effect under the same provisions that govern the Avera *MyPlan* Health Benefits Policy. All other terms, provisions and conditions of this Avera *MyPlan* Health Benefits Policy remain unchanged except as stated in this Benefit Option.

Preventive Services

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- **Additional Preventive Services** –Preventive Services not stated in this Benefit Option will be processed to your appropriate Deductible and Coinsurance limits.
- **Reminder** - Please keep this Preventive Services Benefit Option with your Avera *MyPlan* Health Benefits Policy and other important insurance papers.
- **Contact Information** - Avera Health Plans, Inc.
3900 West Avera Drive
Sioux Falls, SD 57108
1 (888) 322-2115 (phone)
(605) 322-4540 (fax)
www.AveraHealthPlans.com

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Preventive Services Benefit Option

Preventive Services	In-Network	Out of Network
Annual Physical Exam <ul style="list-style-type: none"> • Office Visit only • 1 visit per calendar year 	\$20 Co-pay	No Coverage
Well Woman Exam <ul style="list-style-type: none"> • 1 visit per calendar year • Services include the Office Visit, Pap Smear, Wet Smear, Breast and Pelvic Exam, Hemoglobin and Urinalysis 	\$20 Co-pay	No Coverage
Well Child Exam <ul style="list-style-type: none"> • Office Visit only 	\$20 Co-pay	No Coverage
Prostate Screening <ul style="list-style-type: none"> • 1 per calendar year if: <ul style="list-style-type: none"> ○ history of prostate cancer; or ○ age 45-49 if high risk; or ○ age 50 and over 	100%	No Coverage
Lipid Screening <ul style="list-style-type: none"> • 1 per 5-year period 	100%	No Coverage
Glucose Screening <ul style="list-style-type: none"> • 1 per 3-year period 	100%	No Coverage
Mammogram <ul style="list-style-type: none"> • 1 baseline between age 35-39 • 1 per calendar year after age 40 • Screenings can be more frequent if there is a family history of breast cancer or as approved by Avera Health Plans and would apply to your appropriate deductible and coinsurance limits 	100%	No Coverage
Colorectal Testing <ul style="list-style-type: none"> • Fecal Occult only, 1 per calendar year • Starting at age 50 	100%	No Coverage
Routine Immunizations	100%	No Coverage

***Note:** Additional Preventive Services not listed above will be processed to your appropriate deductible and coinsurance limits.