

# Avera MyPlan

Health care benefits for individuals

## Benefit Summary - MyPlan #4

Benefits	In Network	Out of Network
<b>Deductibles</b>		
Individual	\$2,000*	\$5,000*
Family	\$4,000*	\$10,000*
<b>Coinsurance</b>	60%	60%
<b>Out of Pocket Maximum (Includes medical deductible and coinsurance)</b>		
Individual	\$4,000	No Maximum Limit
Family	\$8,000	No Maximum Limit
<b>Maximum Lifetime Benefit</b>		\$2 Million
<b>Medical Office Visit</b>		
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
<b>Preventive Health Services (With any participating Physician, PA, or NP)</b>		
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
<b>Emergency Services</b>	60% after deductible	60% after deductible
<b>Laboratory and X-Ray Services</b>	60% after deductible	60% after deductible
<b>Inpatient Hospital Services</b>	60% after deductible	60% after deductible
Inpatient Rehabilitative Services (30 day maximum per calendar year)		
<b>Inpatient Physician Services and Consultations</b>	60% after deductible	60% after deductible
<b>Outpatient Hospital Services</b>	60% after deductible	60% after deductible
<b>Outpatient Surgery</b>	60% after deductible	60% after deductible
<b>Home Health Care (1 visit is a maximum of 4 hours)</b> (60 visit maximum per calendar year)	60% after deductible	60% after deductible

Benefits	In Network	Out of Network
<b>Hospice Care</b> Inpatient Outpatient (Combined inpatient and outpatient 185 day maximum benefit while covered under plan)	60% after deductible 60% after deductible	60% after deductible 60% after deductible
<b>Skilled Nursing Facility Service</b> Same confinement if readmitted with same diagnosis within 60 days	60% after deductible 100 days/confinement max	60% after deductible 60 days/confinement max
<b>Ambulance and Other Transportation Services</b>	60% after deductible	60% after deductible
<b>Mental Health Services</b> Inpatient Outpatient (20 visit maximum per calendar year)	60% after deductible 60% after deductible	60% after deductible 60% after deductible
<b>Alcohol Dependency Treatment Services</b> 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 and applied to inpatient limits)	60% after deductible 60% after deductible 60% after deductible	60% after deductible 60% after deductible 60% after deductible
<b>Chemical Dependency Treatment Services</b> 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 and applied to inpatient limits)	60% after deductible 60% after deductible 60% after deductible	60% after deductible 60% after deductible 60% after deductible
<b>Durable Medical Equipment (\$1,000 paid maximum per calendar year)</b>	60% after deductible	60% after deductible
<b>Orthopedic and Prosthetic Devices</b>	60% after deductible	60% after deductible
<b>Outpatient Rehabilitative Therapy</b> includes PT, OT, and ST (20 visit limit for each per calendar year)	60% after deductible	60% after deductible
<b>Outpatient Cardiac Rehabilitation-Phase II</b> (20 visit maximum per calendar year)	60% after deductible	60% after deductible
<b>Transplant Services</b>	60% after deductible	No Coverage
<b>Chiropractic Office Visit (20 visit maximum per calendar year)</b>	\$25 copay (3 visit limit; deductible and coinsurance follow)	No Coverage
<b>Prescription Drugs (3x copay for 90-day supply)</b> 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

\*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.