(605) 322-4545 Toll-Free: 1 (888) 322-2115
www.AveraHealthPlans.com

Non-Grandfathered *MyPlan* $5,000 with Co-pay

Avera MyPlan

Benefit Summary

Medical Coverage		You Pay In-Network	You Pay Out-of-Network
Medical Deductible			
Amount you pay each year before we begin paying for most of your covered services.			
Individual		$5,000	$5,000
Family		$10,000	$10,000
Medical Coinsurance			
Percentage you pay for most covered services after you have met your deductible, until you reach your out-of-pocket maximum.		30%	40%
Medical Out-of-Pocket Maximum			
Maximum total amount of deductible and coinsurance you pay out of your pocket for covered services during the year.			
Individual		$10,000	No Maximum Limit
Family		$20,000	No Maximum Limit
Medical Office Visit			
Primary Care Physician		$25 Co-pay	40% after Deductible
Specialist		$40 Co-pay	40% after Deductible
Preventive Care Services			
Well Child	Office Visit Only - up to age 7	0%	100%
Annual Physical Exam	Office Visit Only - age 7 and up	0%	100%
Annual Well Woman	Includes office visit, pap smear, hemoglobin and urinalysis	0%	100%
Routine Immunizations		0%	100%
Mammogram	1 baseline between age 35-39 and annual starting at age 40	0%	100%
Prostate Cancer Screening	Annual starting at age 50; age 45-49 if high-risk or history of prostate cancer	0%	100%
Colorectal Screening	Starting age 50 - option of annual fecal occult blood, choice of double contrast barium enema and/or flexible sigmoidoscopy every 5 years or screening colonoscopy every 10 years	0%	100%
Lipid Screening	1 every 5 years	0%	100%
Glucose Screening	1 every 3 years	0%	100%
Osteoporosis Testing	1 baseline starting at age 50	0%	100%
Emergency Care Services		30% after Deductible	30% after Deductible
Laboratory and X-ray Services			
Physician Office		30% after Deductible	40% after Deductible
Reference Laboratory		30% after Deductible	40% after Deductible
Inpatient		30% after Deductible	40% after Deductible
Outpatient		30% after Deductible	40% after Deductible
Hospital Services (Precertification required for inpatient services)			
Inpatient		30% after Deductible	40% after Deductible
Outpatient		30% after Deductible	40% after Deductible

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Avera *MyPlan*
Benefit Summary Continued

Medical Coverage	You Pay In-Network	You Pay Out-of-Network
Inpatient Physician Services and Consultations	30% after Deductible	40% after Deductible
Surgical Services	30% after Deductible	40% after Deductible
Home Health Services (One visit is a maximum of 4 hours)	30% after Deductible	40% after Deductible 60-visit limit per plan year
Hospice Services (Combined inpatient and outpatient 185-day maximum per policy year)		
Inpatient	30% after Deductible	40% after Deductible
Outpatient	30% after Deductible	40% after Deductible
Skilled Nursing Facility Services (Same confinement limit if readmitted with same diagnosis within 60 days)	30% after Deductible 100 days/confinement limit	40% after Deductible 60 days/confinement limit
Ambulance and Transportation Services	30% after Deductible	30% after Deductible
Mental Health, Alcohol and Chemical Dependency Treatment (Precertification required for inpatient services)		
Inpatient	30% after Deductible	40% after Deductible
Outpatient	30% after Deductible	40% after Deductible
Office Visit	30% after Deductible	40% after Deductible
Durable Medical Equipment Precertification required on the following items: ▪ Negative Pressure Wound Pump, C-PAP, Bi-PAP, V-PAP, CPROM ▪ Wheelchairs ▪ DME items (rental or purchase) over $5,000	30% after Deductible	100%
Outpatient Rehabilitative Therapy - Physical, occupational and speech therapy (Precertification required after 30 visits per policy year for each therapy)	30% after Deductible	40% after Deductible
Outpatient Cardiac Rehabilitation-Phase II (36-visit maximum per policy year)	30% after Deductible	40% after Deductible
Transplant Services (Precertification required for all services)	30% after Deductible	100%
Chiropractic Office Visit (Precertification required after 20 visits per policy year)	$25 Co-pay	100%
Annual Limit The total amount paid by us for each covered member per policy year	$2 Million	

Pharmacy Coverage	You Pay In-Network		You Pay Out-of-Network
Pharmacy Deductible	**Individual $500** **Family $1000**		
Prescription Drugs	**30-Day Supply**	**90-Day Supply***	
Generic Drugs (deductible and coinsurance waived)	$12 Co-pay	$36 Co-pay	100%
Brand-Name Drugs	20% after Rx Deductible	20% after Rx Deductible	100%

* Maintenance drugs may be dispensed in 90-day supply through mail order or through a participating pharmacy that has agreed to dispense 90-day supply.

* Prior authorization: some prescriptions require prior authorization before they may be obtained.

In-network, out-of-network and prescription benefits accumulate separately. To find an in-network health care provider, refer to your online directory at www.AveraHealthPlans.com and click Member Login or call our Service Center at (605) 322-4545 or toll-free at 1 (888) 322-2115.

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