

Benefit Summary

Medical Coverage	You Pay	
	In-Network	Out-of-Network
Medical Deductible Amount you pay each policy year before we begin paying for most of your covered services. Individual Family	\$5,000 \$10,000	\$5,000 \$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 policy year. Individual Family	\$10,000 \$20,000	No Maximum Limit No Maximum Limit
Medical Office Visit Primary Care Physician Specialist	30% after Deductible 30% after Deductible	40% after Deductible 40% after Deductible
Preventive Care Services <i>Please visit www.AveraHealthPlans.com for a complete list of covered preventive services.</i> Well Child Office Visit Only - up to age 7 Annual Physical Exam Office Visit Only - age 7 and up Annual Well Woman Includes office visit, pap smear, hemoglobin and urinalysis Routine Immunizations Mammogram 1 baseline between age 35-39 and annual starting at age 40 Prostate Cancer Screening Annual starting at age 50; age 45-49 if high-risk or history of prostate cancer 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 Lipid Screening 1 every 5 years Glucose Screening 1 every 3 years Osteoporosis Testing 1 baseline starting at age 50	0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	100% 100% 100% 100% 100% 100% 100% 100% 100%
Emergency Care Services	30% after Deductible	30% after Deductible
Laboratory and X-ray Services Physician Office Reference Laboratory Inpatient Outpatient	30% after Deductible 30% after Deductible 30% after Deductible 30% after Deductible	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Hospital Services (Pre-certification required for inpatient services) Inpatient Outpatient	30% after Deductible 30% after Deductible	40% after Deductible 40% after Deductible

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Benefit Summary Continued

Medical Coverage	You Pay	
	In-Network	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 (1 visit is a maximum of 4 hours)	30% after Deductible	40% after Deductible 60-visit limit per policy 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 (Pre-certification 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 Pre-certification 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 (Pre-certification 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 (Pre-certification required for all services)	30% after Deductible	100%
Chiropractic Office Visit (Pre-certification required after 20 visits per policy year)	30% after Deductible	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
	Individual	Family	
Pharmacy Deductible	\$500		
	\$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 our online directory at www.AveraHealthPlans.com or call our Service Center at (605) 322-4545 or toll-free at 1 (888) 322-2115.