Avera MyPlan

Health care benefits for individuals

Benefit Summary - MyPlan #3

Benefits	In Network	Out of Network
Deductibles		
Individual	$5,000*	$5,000*
Family	$10,000*	$10,000*
Coinsurance	70%	60%
Out of Pocket Maximum (Includes medical deductible and coinsurance)		
Individual	$10,000	No Maximum Limit
Family	$20,000	No Maximum Limit
Maximum Lifetime Benefit	$2 Million	
Medical Office Visit		
Primary and Specialist Care	70% after deductible	60% after deductible
Preventive Health Services (With any participating Physician, PA, or NP)		
Well Child (Office Visit Only)	70% after deductible	No Coverage
Annual Physical Exam 1 per calendar year (Office Visit Only)	70% after deductible	No Coverage
Well Woman 1 per calendar year (Including pap smear, hemoglobin and urinalysis)	70% after deductible	No Coverage
Routine Immunizations	70% after deductible	No Coverage
Screening Mammogram (1 baseline age 35-39; Annual after age 40)	70% after deductible	No Coverage
PSA Screening (Annual if history of prostate cancer, age 45-49 at high risk or starting at age 50)	70% after deductible	No Coverage
Colorectal (fecal occult only, 1 per calendar year) age 50 and over	70% after deductible	No Coverage
Lipid Screening (1 every 5 years)	70% after deductible	No Coverage
Glucose Screening (1 every 3 years)	70% after deductible	No Coverage
Emergency Services	70% after deductible	70% after deductible
Laboratory and X-ray Services	70% after deductible	60% after deductible
Inpatient Hospital Services	70% after deductible	60% after deductible
Inpatient Rehabilitative Services (30-day maximum per calendar year)		
Inpatient Physician Services and Consultations	70% after deductible	60% after deductible
Outpatient Hospital Services	70% after deductible	60% after deductible
Outpatient Surgery	70% after deductible	60% after deductible
Home Health Care (1 visit is a maximum of 4 hours)	70% after deductible	60% after deductible
(60-visit maximum per calendar year)		
Hospice Care		
Inpatient	70% after deductible	60% after deductible
Outpatient	70% after deductible	60% after deductible
(Combined inpatient and outpatient 185-day maximum benefit while covered under plan)		

Benefits	In Network	Out of Network
Skilled Nursing Facility Service	70% after deductible	60% after deductible
Same confinement if readmitted with same diagnosis within 60-days	100 days/confinement max	60 days/confinement max
Ambulance and Other Transportation Services	70% after deductible	70% after deductible
Mental Health Services		
Inpatient	70% after deductible	60% after deductible
Outpatient (20-visit maximum per calendar year)	70% after deductible	60% after deductible
Alcohol Dependency Treatment Services		
Inpatient (30-daymax/6-month period and 90-day maximum benefit while covered under plan)	70% after deductible	60% after deductible
Outpatient (30-visit max/6-month period and 90-day maximum benefit while covered under plan)	70% after deductible	60% after deductible
Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	70% after deductible	60% after deductible
Chemical Dependency Treatment Services		
Inpatient (30-daymax/6-month period and 90-day maximum benefit while covered under plan)	70% after deductible	60% after deductible
Outpatient (30 visit max/6month period and 90 day maximum benefit while covered under plan)	70% after deductible	60% after deductible
Partial Day Program (equivalent to 1/2 day and applied to inpatient limits)	70% after deductible	60% after deductible
Durable Medical Equipment ($1,000 paid maximum per calendar year)	70% after deductible	60% after deductible
Orthopedic and Prosthetic Devices	70% after deductible	60% after deductible
Outpatient Rehabilitative Therapy	70% after deductible	60% after deductible
includes PT, OT, and ST (20-visit limit for each per calendar year)		
Outpatient Cardiac Rehabilitation-Phase II	70% after deductible	60% after deductible
(20-visit maximum per calendar year)		
Transplant Services	70% after deductible	No Coverage
Chiropractic Office Visit (20-visit maximum per calendar year)	70% after deductible	No Coverage
Prescription Drugs (3x copay for 90 day supply)		
Generic	$10 copay applies (deductible and coinsurance waived)	No Coverage
Deductible - Individual	$500*	No Coverage
Family	$1,000*	No Coverage
Brand Name	80% after RX deductible	No Coverage

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

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