

Outline of Benefits

Avera MyPlan has five different plan options available. This is an outline of benefits for In-Network coverage and it is not a guarantee of benefits. Please remember all services are eligible for coverage based on medical necessity and are subject to the appropriate limitations and exclusions located in the Policy and Benefit Summaries.

The Out-of-Network deductible with each policy is \$5,000 for individual and \$10,000 for the family. The coinsurance the health plan pays after the deductible is 60% and the out-of-pocket does not have a maximum limit.

Please refer to Avera Health Plans web site at www.AveraHealthPlans.com for a list of participating providers or call our Service Center toll-free at 1 (888) 322-2115 or (605) 322-4545 to request a copy of the Provider Directory.

Note: This document is a summary of coverage. Please refer to the Avera MyPlan Policy and Benefit Summaries for actual benefits, limitations and exclusions.

Benefit Limitations	\$1,500 Plan #1	\$3,000 Plan #2	\$5,000 Plan #3	\$2,000 Plan #4	HSA Qualified Plan
Deductible. The first \$300 or \$500 of incurred covered medical expense on plans 1 and 2 do not apply towards the deductible. It is a calendar year deductible so a new deductible is required starting January 1 of every year. Individual Family	\$300 First dollar coverage \$1,500 \$3,000	\$500 First dollar coverage \$3,000 \$6,000	\$5,000 \$10,000	\$2,000 \$4,000	\$2,500 \$5,000
Out-of-Pocket Maximum. Includes deductible and coinsurance amounts; first dollar amounts do not apply. The plan will pay 100% of allowed charges after the Out-of-Pocket Maximum is met for in-network services. Individual Family	\$3,500 \$7,000	\$7,000 \$14,000	\$10,000 \$20,000	\$4,000 \$8,000	\$5,000 \$10,000
Coinsurance. Amount paid by the health plan after the deductible is met.	80%	80%	70%	60%	80%
Lifetime Maximum	\$2 Million	\$2 Million	\$2 Million	\$2 Million	\$2 Million
Medical Office Visit. Deductible and coinsurance apply for lab and X-ray services. This benefit applies to services received by a PCP (any participating Primary Care Physician) or specialist.	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	\$25 co-pay 5 visit limit /member (deductible and coinsurance follow)	Deductible and coinsurance
X-ray and Lab Tests.	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Included in Office Visit Co-pay	Deductible and coinsurance
Preventive Care. Limited per plan guidelines. This benefit applies to services received with any participating Physician, PA or NP. This includes: Immunizations Well Child (Office visit only) Routine Adult Preventive Care	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	\$25 co-pay	Deductible and coinsurance
Inpatient Hospitalization Services. Inpatient Rehabilitative Services has a 30 day maximum per calendar year. It is the	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance

Member's responsibility to assure that any hospital stays are precertified through Avera Health Plans.					
Outpatient Surgery & Hospital Services.	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Emergency/Urgent Care. This includes: Emergency Care/Ambulance/Emergency Transportation (In-network benefit levels apply)	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Chiropractic Office Visit. This has a maximum of 20 visits per calendar year.	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	\$25 co-pay 3 visit limit/member (deductible and coinsurance follow)	Deductible and coinsurance
Chemical Dependency Services. This includes: Inpatient Limited to 30 days per 6-month period 90 days per lifetime maximum Outpatient Limited to 30 days per 6-month period 90 days per lifetime maximum	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Behavioral Health Care. This includes: Inpatient/Outpatient 20-visit maximum per calendar year	* Deductible and coinsurance	*Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Prescription Drugs. (does not include contraceptives) Pharmacy Deductible Individual Family (waived for generic) Generic Drugs Brand Name Drugs Prescription Drugs (90-day supply)	\$500 \$1,000 \$10 co-pay Plan pays 80% after deductible Mail Order	\$500 \$1,000 \$10 co-pay Plan pays 80% after deductible Mail Order	\$500 \$1,000 \$10 co-pay Plan pays 80% after deductible Mail Order	\$500 \$1,000 \$10 co-pay Plan pays 80% after deductible Mail Order	Deductible and coinsurance

* Please note these services are subject to the first dollar coverage. Once the first dollar coverage is exhausted, the applicable deductible and coinsurance apply.

Additional Options	In-Network Benefits	Out-of-Network Benefits
Maternity (routine prenatal and postnatal care and delivery/per pregnancy) <ul style="list-style-type: none"> Deductible Coinsurance (amount health plan pays after deductible is met) Maximum Out-of-Pocket 	\$2,000 70% \$5,000	\$5,000 60% No Maximum Limit
Dental <ul style="list-style-type: none"> Routine Oral Exam (2 visits per calendar year) Bitewing X-ray (1 set per 12-month period; up to 4 films) Full Mouth X-ray (1 scan per 36-month period) Sealants on the Occlusal Surface of Permanent Posterior Tooth (1 per 36-month period) Fluoride Application 	\$25 co-pay 100% Covered 100% Covered 100% Covered 100% Covered	Not Applicable
Vision <ul style="list-style-type: none"> One complete Routine Eye Examination per 12-month period with a participating VSP (Vision Services Plan) provider Lenses and Frames at 20% discount Contact Lens Services at a 15% discount 	100%	No Coverage
Preventive (Option is only available for Plan 3 and HSA. Please see separate sheet.)		

