



**Avera Health Plans, Inc.  
HSA Plan**

Benefits	In Network	Out of Network
<b>Deductibles</b> Individual Family* *Options available for either a true family deductible or an embedded deductible as of 1/1/07	<b>Ranges</b> \$1,250-\$5,000 \$2,500-\$10,000	\$5,000/\$10,000
<b>Out of Pocket Maximum Options</b> Individual Family Copay +Deductible +Coinsurance=OOP Max	<b>Ranges</b> \$1,250-\$5,250 \$2,500-\$10,500	\$10,000/\$15,000
<b>Coinsurance Percentage Options</b>	70% 80% 90% 100%	60%
<b>Medical Office Visit</b> <i>(Deductible &amp; coinsurance for Lab &amp; X-ray)</i> PCP (Any participating PCP) Specialist	% after Deductible % after Deductible	60% after Deductible 60% after Deductible
<b>Preventive Health Services</b> <b>Well Baby</b> (office visit only) <b>Annual Physical Exam</b> (1 per year) <b>Well Woman</b> (1 per year) <b>Routine Immunizations</b> <b>Mammograms</b> (According to schedule) <b>PSA Screening</b> (According to schedule) <b>Colorectal Screening</b> <b>Lipid Screening</b> (1 every 5 years) <b>Glucose Screening</b> (1 every 3 years) <b>Osteoporosis Screening</b> (1 baseline after age 50)	% after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible	No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage No Coverage
<b>Health Services</b> <b>Emergency &amp; Ambulance Services</b> <b>Employee Assistance Program</b> Up to 3 counseling sessions per member <b>Lab &amp; X-Ray Services</b> <b>Inpatient Hospital Services</b> <b>Routine Maternity, Pregnancy &amp; Newborn Care</b> <b>Inpatient Physician Services &amp; Consultations</b> <b>Outpatient Hospital Services</b> <b>Outpatient Surgery</b> <b>Home Health Care</b> (1 visit is max of 4 hrs.) <b>Hospice Care</b> Inpatient Outpatient (Combined inpatient & outpatient 185 day max benefit while covered under plan) <b>Skilled Nursing Facility Service</b>	% after Deductible 100% coverage % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible % after Deductible	% after In Network Deductible No Coverage 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible

List may be subject to change. This is a summary only and does not contain all benefits available.



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Benefits	In Network	Out of Network
<b>Health Services Continued</b>		
<b>Mental Health Services</b>		
Inpatient	% after Deductible	60% after Deductible
Outpatient (20 visit max per calendar year)	% after Deductible	60% after Deductible
<b>Alcohol &amp; Chemical Treatment Services</b>		
Inpatient (30 day max/6 month period & 90 max benefit while covered under plan)	% after Deductible	60% after Deductible
Outpatient (30 day max/6 month period & 90 max benefit while covered under plan)	% after Deductible	60% after Deductible
Partial Day Program (equivalent to 1/2 day & applied to inpatient limits)	% after Deductible	60% after Deductible
<b>Durable Medical Equipment</b> (\$1000 yearly paid max)	% after Deductible	No Coverage
<b>Outpatient Rehabilitative Therapy</b>	% after Deductible	60% after Deductible
<b>Outpatient Cardiac Rehabilitation-Phase II</b>	% after Deductible	60% after Deductible
<b>Transplant Services</b>	% after Deductible	No Coverage
<b>Chiropractic Office Visit</b> (max 20 visits per calendar year)	% after Deductible	No Coverage
<b>Prescription Drugs</b> (formulary applies)	% after Deductible	No Coverage
<b>HSA Options</b>		
<b>Preventive Health Services</b>		
<b>Well Baby</b> (office visit only)	100%	No Coverage
<b>Annual Physical Exam</b> (1 per year)	\$10 Copay	No Coverage
<b>Well Woman</b> (1 per year)	\$10 Copay	No Coverage
<b>Routine Immunizations</b>	100%	No Coverage
<b>Mammograms</b> (According to schedule)	100%	No Coverage
<b>PSA Screening</b> (According to schedule)	100%	No Coverage
<b>Colorectal Screening</b>	100%	No Coverage
<b>Lipid Screening</b> (1 every 5 years)	100%	No Coverage
<b>Glucose Screening</b> (1 every 3 years)	100%	No Coverage
<b>Osteoporosis Screening</b> (1 baseline after age 50)	100%	No Coverage

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Avera Health Plans has partnered with Wells Fargo to provide a variety of investment options. Wells Fargo charges an administrative fee of \$4.25 per month per participant. You may obtain more information on Wells Fargo by visiting [www.wfhbs.com/averahealthplans](http://www.wfhbs.com/averahealthplans). The employer group does have the option to select their own fiduciary vendor.