Individual & Family Plan Options

In-network benefits are provided in the charts in this booklet.

For out-of-network benefits or more details, please refer to the Summary of Benefits and Coverage found at AveraHealthPlans.com, under the Shop Plans for Individuals section.

- *These plans are considered High-Deductible Health Plans (HDHP) that can be paired with a Health Savings Account (HSA).
- **Examples include gynecological exam, screening mammography, well-child care and newborn care. Limitations do apply. For a detailed listing, visit AveraHealthPlans.com.
- ***Visits to Primary Care, Chiropractic, Urgent Care and Mental Health Outpatient Services combined apply to the 3 visit benefit total. It is not 3 visits per coverage category.
- **** To qualify for this plan you must be under the age of 30 before the policy effective date or qualify for a federal hardship exemption
- † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization.

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113). LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).

Traditional Plans

Application ID # ___

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	Avera 1500	Avera 2750	Avera 3500	Avera 4200 HDHP*	Avera 6000	Avera 6750 HDHP*	Avera 8150****
Deductible							
Individual	\$1,500	\$2,750	\$3,500	\$4,200	\$6,000	\$6,750	\$8,150
Family	\$3,000	\$5,500	\$7,000	\$8,400	\$12,000	\$13,500	\$16,300
Coinsurance							
	30%	30%	40%	0%	50%	0%	0%
Out-of-Pocket Maximum							
Individual	\$5,000	\$7,500	\$7,500	\$4,200	\$8,150	\$6,750	\$8,150
Family	\$10,000	\$15,000	\$15,000	\$8,400	\$16,300	\$13,500	\$16,300
Medical Benefits							
Preventive Care Services			No cost to you. This inclu	ıdes preventive immunizati	ons, screenings, exams*	*	
Primary Care Physician Visit	Co-pay \$25		Co-pay \$50		Co-pay \$50/visit*** for the first 3 visits then subject to Deductible/ 50% Coinsurance		Co-pay \$0/visit*** for the first 3 visits, then subject t Deductible/ 0% Coinsurance
Specialist Visit	Co-pay \$50	Deductible/ 30% Coinsurance	Co-pay \$80	This is an HSA-compatible plan. Please note: Cost Share Reduction plans may not qualify	Deductible/ 50% Coinsurance	This is an HSA-compatible plan.	Deductible/ 0% Coinsurance
Urgent Care Services	Co-pay \$25		Co-pay \$50		Co-pay \$50/visit*** for the first 3 visits then subject to Deductible/ 50% Coinsurance		Co-pay \$0/visit*** for the first 3 visits, then subject to Deductible/ 0% Coinsurance
Lab and X-Ray (Diagnostic Test)	Deductible/ 30% Coinsurance		Deductible/ 40% Coinsurance	You will pay \$0 after	Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Deductible	Deductible/ 0% Coinsurance
Hospital Services				meeting the Deductible			
Emergency Services	Deductible and Coinsurance apply for all plans				Deductible and Coinsurance apply		Deductible and Coinsurance apply
Maternity Services							Comparation apply
Pediatric Vision Services				Leaf start Start Later			
Pediatric Dental Services				Included with all plans			
Chiropractor Visit †	Co-pay \$25	Deductible/ 30% Coinsurance	Co-pay \$50	This is an HSA-compatible plan.	Co-pay \$50/visit*** for the first 3 visits, then subject to Deductible/ 50% Coinsurance	This is an HSA- compatible plan.	Co-pay \$0/visit*** for the first 3 visits, then subject to Deductible/ 0% Coinsurance
AveraNow	No cost to the member			Please note: Cost	No cost to the member	Please note: Cost	No cost to the memb
Mental Health and Substance Use Disorder				Share Reduction plans		Share Reduction plans	
Outpatient Services	Co-pay \$25	Deductible/ 30% Coinsurance	Co-pay \$50	may not qualify You will pay \$0 after	Co-pay \$50/visit*** for first 3 visits then subject to Deductible/ 50% Coinsurance	may not qualify You will pay \$0 after	Co-pay \$0/visit*** for the first 3 visits, then subject t Deductible/ 0% Coinsurance
Inpatient Services	Deductible and Coinsurance apply for all plans			meeting the Deductible	Deductible and Coinsurance apply	meeting the Deductible	Deductible and Coinsurance apply
Pharmacy Benefits							
Pharmacy Deductible - Individual	\$0	\$0	\$50	\$0	\$50	\$0	\$0
- Family	\$0	\$0	\$100	\$0	\$100	\$0	\$0
Tier 1: Preventive Drugs	\$0	\$0	\$0		\$0		
Tier 2: Preferred Generics	\$0	Φ0	\$10	Tier 1 = \$0	\$15	Tier 1 = \$0	T:1
Tier 3: Non-Preferred Generics	\$50		\$30		\$35		Tier 1 = \$0
Tier 4: Preferred Brands	\$50	Medical Deductible/	\$50	You will pay \$0 after	\$75	You will pay \$0 after	You will pay \$0 afte
Tier 5: Non-Preferred Brands	\$150	30% Coinsurance	\$100	meeting the Medical	\$150	meeting the Medical	meeting the Medic
Tier 6: Specialty Drugs (brand and generic)	30% Coinsurance/ \$250 maximum		40% Coinsurance/ \$250 maximum	Deductible	40% Coinsurance/ \$250 maximum	Deductible	Deductible
	Gold	Silver	Silver	Silver	Bronze	Expanded Bronze	Catastrophic
Quote:	\$	\$	\$	\$	\$	\$	\$