2019 Plan Options for Individuals and Families

In-network benefits are described on the charts.

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.

Plan Details:

- *These plans are considered highdeductible health plans (HDHP) that can be paired with a Health Savings Account.
- **Examples include gynecological exam, screening mammography, well-child care and newborn care. Limitations do apply. For a detailed listing, visit AveraHealthPlans.com.
- *** 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



					Application ID #			
Plans	Avera 1500	Avera 2750	Avera 3500	Avera 4000*	Avera 5500	Avera 6750*	Avera 7900***	
Deductible								
Individual	\$1,500	\$2,750	\$3,500	\$4,000	\$5,500	\$6,750	\$7,900	
Family	\$3,000	\$5,500	\$7,000	\$8,000	\$11,000	\$13,500	\$15,800	
Coinsurance								
	30%	30%	40%	0%	40%	0%	0%	
Out-of-Pocket Maximum								
Individual	\$3,500	\$7,100	\$7,500	\$4,000	\$7,900	\$6,750	\$7,900	
Family	\$7,000	\$14,200	\$15,000	\$8,000	\$15,800	\$13,500	\$15,800	
Medical Benefits								
Preventive Care Services		No	cost to you. This inc	cludes preventive ir	mmunizations, screenings, exams	* *		
Primary Care Physician Visit	Co-pay \$25		Co-pay \$50	This is an HSA-	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	This is an HSA-	Co-pay \$0 Maximum 3 visits	
Specialist Visit	Co-pay \$50	Deductible/ 30%	Co-pay \$80	compatible plan. Please note: Cost Share Reduction plans may not qualify	Deductible/ 40% Coinsurance	compatible plan. Please note: Cost Share Reduction plans may not qualify	Deductible/ 0% Coinsurance	
Urgent Care Services	Co-pay \$25	Coinsurance	Co-pay \$50		Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance		Co-pay \$0 Maximum 3 visits	
Lab and X-Ray (Diagnostic Test)	Deductible/ 30% Coinsurance		Deductible/ 40% Coinsurance		Deductible/ 40% Coinsurance		Deductible/ 0% Coinsurance	
Hospital Services				You will pay \$0		You will pay \$0		
Emergency Services	Deductible and coinsurance apply for all plans			after meeting the deductible	Deductible and coinsurance apply	after meeting the deductible	Deductible and coinsurance	
Maternity Services							apply	
Pediatric Vision Services				Included with	all plans			
Pediatric Dental Services								
Chiropractor Visit	Co-pay \$25	Deductible/ 30% Coinsurance	Co-pay \$50	This is an HSA- compatible plan.	Co-pay \$40/visit for the first three visits, then subject to Deductible/ Coinsurance	This is an HSA-compatible plan.	Co-pay \$0 Maximum 3 visits	
AveraNow	No cost to the member		Please note: Cost Share Reduction	No cost to the member	Please note: Cost Share Reduction	No cost		
Mental Health and Substance U	se Disorder			plans may not		plans may not		
Outpatient Services	Co-pay \$25	Deductible/ 30% Coinsurance	Co-pay \$50	qualify You will pay \$0	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	qualify You will pay \$0	Co-pay \$0 Maximum 3 visits	
Inpatient Services	Deductible ar	actible and coinsurance apply for all plans		after meeting the deductible	Deductible and coinsurance apply	after meeting the deductible	Deductible and coinsurance apply	
Pharmacy Benefits								
Pharmacy Deductible - Individual	\$0	\$0	\$0	\$0	\$50	\$0	\$0	
- Family	\$0	\$0	\$0	\$0	\$100	\$0	\$0	
Tier 1: Preventive Medications	\$0	\$0	\$0		\$0			
Tier 2: Preferred Generics	\$0		\$10	Tier 1 = \$0	\$10	Tier 1 = \$0	Tier 1 = \$0	
Tier 3: Non-Preferred Generics	\$50	Medical	\$30	You will pay \$0 after meeting the medical deductible	\$30	You will pay \$0 after meeting the medical deductible	You will pay \$0	
Tier 4: Preferred Brands	\$50	Deductible/	\$50		\$75		after meeting	
Tier 5: Non-Preferred Brands	\$150	30% Coinsurance	\$100		\$150		the medical	
	30% Coinsurance/	Comsulance	40% Coinsurance/		40% Coinsurance/ \$250 maximum		deductible	
Tier 6: Specialty Medications (brand and generic)	\$250 maximum		\$250 maximum		Ψ200 ΠαλίΠαΠΙ			
	\$250 maximum Gold	Silver	\$250 maximum Silver	Silver	Bronze	Bronze	Catastrophic	

Level 1: Avera providers | Level 2: Other in-network providers Application ID #

Level 1: Avera providers Level 2: Other in-network providers Application ID #						
Additional plans for residents in Brown, Lincoln and	Avera Preferred 2750		Avera Pref	erred 3500	Avera Preferred 5500	
Minnehaha counties only	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2
Deductible						
Individual	\$2,750	\$2,750	\$3,500	\$3,500	\$5,500	\$5,500
Family	\$5,500	\$5,500	\$7,000	\$7,000	\$11,000	\$11,000
Coinsurance						
	30%	40%	40%	50%	40%	50%
Out-of-Pocket Maximun	n					
Individual	\$7,100	\$7,100	\$7,500	\$7,500	\$7,900	\$7,900
Family	\$14,200	\$14,200	\$15,000	\$15,000	\$15,800	\$15,800
Medical Benefits						
Preventive Care Services	No co	ost to you. This	includes preve	entive immuniz	ations, screenings,	exams**
Primary Care Physician Visit			Co-pay \$50	Co-pay \$70	Co-pay \$40/visit for first three visits then subject to Deductible/ 40% Coinsurance	
Specialist Visit		Deductible/	Co-pay \$80	Co-pay \$100	Deductible/ 40% Coinsurance	Deal allelat
Urgent Care Services	Deductible/	40% Coinsurance	Co-pay \$50	Co-pay \$70	Co-pay \$40/visit for first three visits then subject to Deductible/ 40% Coinsurance	Deductible/ 50% Coinsurance
Lab and X-Ray (Diagnostic Test)	30% Coinsurance		Deductible/ 40% Coinsurance	Deductible/ 50%	Deductible/ 40% Coinsurance	
Hospital Services				Coinsurance		
Emergency Services		Deductible/ 30% Coinsurance		Deductible/ 40% Coinsurance		Deductible/ 40% Coinsurance
Maternity Services		Deductible/ 40% Coinsurance		Deductible/ 50% Coinsurance		Deductible/ 50% Coinsurance
Pediatric Vision Services			Include	ed with all plan	S	
Pediatric Dental Services		I				
Chiropractor Visit	Deductible/ 30% Coinsurance	Deductible/ 30% Coinsurance	Co-pay \$50	Co-pay \$50	Co-pay \$40/visit for first three visits then subject to Deductible/ 40% Coinsurance	Co-pay \$40/visit for first three visits then subject to Deductible/ 40% Coinsurance
AveraNow			No cos	t to the memb	er	
Mental Health and Subs	stance Use Dis	sorder				
Outpatient Services	Deductible/	Deductible/	Co-pay \$50	Co-pay \$70	Co-pay \$40/visit for first three visits then subject to Deductible/ 40% Coinsurance	Deductible/
Inpatient Services	Coinsurance	Coinsurance	Deductible/ 40% Coinsurance	Deductible/ 50% Coinsurance	Deductible/ 40% Coinsurance	50% Coinsurance
Pharmacy Benefits						
Pharmacy Deductible - Individual	\$0		\$0		\$50	
- Family	\$0		\$0		\$100	
Tier 1: Preventive Medications	\$0		\$0		\$0	
Tier 2: Preferred Generics			\$	10	\$^	10
Tier 3: Non-Preferred Generics	Medical Deductible/ 30% Coinsurance Silver		\$30		\$30	
Tier 4: Preferred Brands			\$50		\$75	
Tier 5: Non-Preferred Brands			\$100		\$150	
Tier 6: Specialty Medications (brand and generic)			40% Coinsurance/ \$250 maximum		40% Coinsurance/ \$250 maximum	
			Silver		Bronze	
Quote:	\$	\$	\$	\$	\$	\$

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Coinsurance		
Individual \$3,000 \$5,200 \$5,000 \$6,88		
Family \$6,000 \$10,400 \$10,000 \$13, Coinsurance 40% 0% 50% 0% Out-of-Pocket Maximum Individual \$6,500 \$5,200 \$7,800 \$6,6 Family \$13,000 \$10,400 \$15,600 \$13, Medical Benefits Preventive Care Services No cost to you. This includes preventive immunizations, screenings, exam Primary Care Physician Visit Co-pay \$40 This is an HSA-compatible plan You will pay \$0 after meeting the deductible/ S0% Coinsurance Pediatric Vision Services Pediatric Vision Services Pediatric Vision Services Pediatric Visit Co-pay \$40 This is an HSA-compatible plan You will pay \$0 after meeting the deductible/ S0% Coinsurance Pediatric Dental Services Pediatric		
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Tier 1: Preventive Medications \$0 \$0	0	
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Tier 2: Preferred Generics \$10 Tier 1 = \$0	Tier 1 = \$0	
Tier 3: Non-Preferred Generics \$30 \$30		
after an extinuit to a	You will pay \$0 after meeting the	
medical deductible medical d	medical deductible	
Tier 6: Specialty Medications (brand and generic) 40% Coinsurance/ \$250 maximum 40% Coinsurance/ \$250 maximum		
Silver Silver Bronze Bro	nze	
Quote: \$ \$ \$ \$		