

2018 Individual & Family

Health Insurance





2018 Plan Options for Individuals and Families

In-network benefits are described on the chart.

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.



DeductibleIndividual\$1,500\$2,750Individual\$1,500\$2,750Family\$3,000\$5,500Coinsurance30%30%Out-of-Pocket Maximum100Individual\$3,500\$7,100Family\$7,000\$14,200Medical Benefits100Preventive Care ServicesNo cost to you. This includes preventive inPrimary Care Physician VisitCo-pay \$25Deductible/ 30% CoinsuranceSpecialist VisitCo-pay \$50Deductible/ 30% CoinsuranceUrgent Care ServicesCo-pay \$25Deductible/ 30% CoinsuranceLab and X-Ray (Diagnostic Test)Deductible/ 30% CoinsuranceDeductible/ 30% CoinsuranceHospital ServicesDeductible and coinsurance apply for all Emergency ServicesDeductible and coinsurance apply for all	On and Off Exchange Plans	Avera 1500	Avera 2750	
Individual\$1,500\$2,750Family\$3,000\$5,500Coinsurance30%30%Out-of-Pocket Maximum30%30%Individual\$3,500\$7,100Family\$7,000\$14,200Medical BenefitsNo cost to you. This includes preventive inPreventive Care ServicesNo cost to you. This includes preventive inPrimary Care Physician VisitCo-pay \$25Deductible/ 30% CoinsuranceSpecialist VisitCo-pay \$25Deductible/ 30% CoinsuranceUrgent Care ServicesDeductible and coinsuranceLab and X-Ray (Diagnostic Test)Deductible and coinsuranceHospital ServicesDeductible and coinsuranceHospital ServicesDeductible and coinsurance apply for all and coinsuranceMaternity ServicesDeductible and coinsurance apply for all and coinsurancePediatric Vision ServicesIncluded with all plans.Pediatric Vision ServicesIncluded with all plans.Pharmacy BenefitsIncluded with all plans.Pharmacy Deductible - Individual\$0-Family\$0Sino -Preferred Generics\$50Tier 1: Preventive Medications\$0Fier 3: Non-Preferred Brands\$150Tier 4: Preferred Brands\$150Tier 5: Non-Preferred Brands\$00Tier 6: Specialty Medications (brand and	Deductible			
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Orgent Care ServicesCo-pay \$2530% CoinsuranceLab and X-Ray (Diagnostic Test) 30% Coinsurance 30% CoinsuranceHospital ServicesDeductible and coi	Specialist Visit	Co-pay \$50		
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Pharmacy BenefitsImage: Second Se	Outpatient Services	Co-pay \$25		
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Tier 2: Preferred Generics\$0Tier 1 = \$0Tier 3: Non-Preferred Generics\$50You will pay \$0Tier 4: Preferred Brands\$50You will pay \$0Tier 5: Non-Preferred Brands\$150deductible.Tier 6: Specialty Medications (brand and generic)30% Coinsurance/ \$250 maximumSilver	- Family	\$0	\$0	
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Tier 3: Non-Preferred Generics\$50You will pay \$0 after meeting the deductible.Tier 4: Preferred Brands\$150You will pay \$0 after meeting the deductible.Tier 5: Non-Preferred Brands\$150after meeting the deductible.Tier 6: Specialty Medications (brand and generic)30% Coinsurance/ \$250 maximumSilver	Tier 2: Preferred Generics	\$0	Tier 1 = \$0	
Tier 4. Preferred Brands\$30after meeting the deductible.Tier 5: Non-Preferred Brands\$150deductible.Tier 6: Specialty Medications (brand and generic)30% Coinsurance/\$250 maximumSilverGoldSilver	Tier 3: Non-Preferred Generics	\$50		
Tier 5: Non-Preferred Brands\$150deductible.Tier 6: Specialty Medications (brand and generic)30% Coinsurance/ \$250 maximumdeductible.GoldSilver	Tier 4: Preferred Brands	\$50		
(brand and generic) \$250 maximum Gold Silver	Tier 5: Non-Preferred Brands	\$150		
Quote: \$ \$		Gold	Silver	
	Quote:	\$	\$	

			Appli	cation ID #	
Avera 2800	Avera 3500	Avera 4000*	Avera 5500	Avera 6550*	Avera 7350
\$2,800	\$3,500	\$4,000	\$5,500	\$6,550	\$7,350
\$5,600	\$7,000	\$8,000	\$11,000	\$13,100	\$14,700
40%	40%	0%	40%	0%	0%
\$6,800	\$7,200	\$4,000	\$7,350	\$6,550	\$7,350
\$13,600	\$14,400	\$8,000	\$14,700	\$13,100	\$14,700
nmunizations, screeni	ings, exams**				
Co-pay \$45	Co-pay \$50	This is an HSA- compatible plan.	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	This is an HSA- compatible plan.	Co-pay \$0 Maximum 3 visits
Co-pay \$75	Co-pay \$80	Please note: Cost Share	Deductible/ 40% Coinsurance	Please note: Cost Share	0% Coinsurance
Co-pay \$45	Co-pay \$50	Reduction plans	Co-pay \$40	Reduction plans	Co-pay \$0 Maximum 3 visits
Deductible/ 40% Coinsurance	Deductible/ 40% Coinsurance	may not qualify.	Deductible/ 40% Coinsurance	may not qualify.	Deductible/ 0% Coinsurance
plans. plans. plans.		You will pay \$0 after meeting the deductible.		You will pay \$0 after meeting the deductible.	
					Included
Co-pay \$45	Со-рау \$50		Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance		Co-pay \$0 Maximum 3 visits
\$0	\$0	\$0	\$50	\$0	\$0
\$0	\$0	\$0	\$100	\$0	\$0
\$0	\$0		\$0		To qualify for this
\$0	\$10	Tier 1 = \$0	\$10	Tier 1 = \$0	To qualify for this plan you must be
\$30	\$30	You will pay \$0	\$30	You will pay \$0	under the age of 30 before Jan.
\$50	\$50	after meeting	\$75	after meeting	1 or qualify for a
\$75	\$100	the deductible.	\$150	the deductible.	federal hardship exemption.
\$150	40% coinsurance/ \$250 maximum		40% coinsurance/ \$250 maximum		

Silver

\$_

Bronze

\$_

Bronze

\$

Catastrophic

\$_

Silver

\$

Silver

\$_

	Application ID #				
Off Exchange Plans	Avera 2500	Avera 3000	Avera 5000	Avera 6000*	
Deductible					
Individual	\$2,500	\$3,000	\$5,000	\$6,000	
Family	\$5,000	\$6,000	\$10,000	\$12,000	
Coinsurance					
	30%	40%	40%	0%	
Out-of-Pocket Maximum					
Individual	\$6,000	\$6,500	\$7,350	\$6,000	
Family	\$12,000	\$13,000	\$14,700	\$12,000	
Medical Benefits					
Preventive Care Services	No cost to you. This inc	cludes preventive immur	nizations, screenings, exams	* *	
Primary Care Physician Visit	Co-pay \$30	Co-pay \$40	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	This is an HSA-	
Specialist Visit	Co-pay \$75	Co-pay \$100	Deductible/ 40% Coinsurance	compatible plan.	
Urgent Care Services	Co-pay \$30	Co-pay \$40	Co-pay \$40	You will pay \$0 after meeting the	
Lab and X-Ray (Diagnostic Test)	Deductible/ 30% Coinsurance	Deductible/ 40% Coinsurance	Deductible/ 40% Coinsurance	deductible.	
Hospital Services	Deductible and coinsurance apply for all plans.				
Emergency Services	Deductible and coinsurance apply for all plans.				
Maternity Services	Deductible and coinsurance apply for all plans.				
Pediatric Vision Services	Included with all plans.				
Pediatric Dental Services	Included with all pla	ans.			
Mental Health and Substance U	se Disorder				
Outpatient Services	Co-pay \$30	Co-pay \$40	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance		
Inpatient Services	Included with all plans.				
Pharmacy Benefits					
Pharmacy Deductible - Individual	\$50	\$50	\$50	\$0	
- Family	\$100	\$100	\$100	\$0	
Tier 1: Preventive Medications	\$0	\$0	\$0		
Tier 2: Preferred Generics	\$10	\$10	\$10	Tier 1 = \$0	
Tier 3: Non-Preferred Generics	\$30	\$30	\$30		
Tier 4: Preferred Brands	\$50	\$50	\$75	You will pay \$0 after meeting the	
Tier 5: Non-Preferred Brands	\$100	\$150	\$150	deductible.	
Tier 6: Specialty Medications (brand and generic)	30% Coinsurance/ \$250 maximum	40% Coinsurance/ \$250 maximum	40% Coinsurance/ \$250 maximum		
	Silver	Silver	Bronze	Bronze	
Avera Health Plans Quote:	\$	\$	\$	\$	

	Appl	Application ID #			
Off Exchange – Stanley Cou		Avera			
Deductible	2500	6250*			
Individual	\$2,500	\$6,250			
Family Coinsurance	\$5,000	\$12,500			
	30%	0%			
Out-of-Pocket Maximum					
Individual	\$6,000	\$6,250			
Family	\$12,000	\$12,500			
Medical Benefits					
Preventive Care Services	No cost to you. This includes preventive in	mmunizations, screenings, exams**			
Primary Care Physician Visit	Co-pay \$30	This is an HSA-			
Specialist Visit	Co-pay \$75	compatible plan.			
Urgent Care Services	Co-pay \$30	You will pay \$0 after meeting the deductible.			
Lab and X-Ray (Diagnostic Test)	Deductible/ 30% Coinsurance				
Hospital Services	Deductible and coinsurance apply for all plans.				
Emergency Services	Deductible and coinsurance apply for all plans.				
Maternity Services	Deductible and coinsurance apply for all plans.				
Pediatric Vision Services	Included with all plans.				
Pediatric Dental Services	Included with all plans.				
Mental Health and Substance Use D	lisorder				
Outpatient Services	Co-pay \$30				
Inpatient Services	Included with all plans.				
Pharmacy Benefits					
Pharmacy Deductible - Individual	\$50	\$0			
- Family	\$100	\$0			
Tier 1: Preventive Medications	\$0				
Tier 2: Preferred Generics	\$10				
Tier 3: Non-Preferred Generics	\$30	Tier 1 = \$0			
Tier 4: Preferred Brands	\$50	You will pay \$0 after			
Tier 5: Non-Preferred Brands	\$100	meeting the deductible.			
Tier 6: Specialty Medications (brand and generic)	30% Coinsurance/ \$250 maximum				
	Silver	Bronze			
Avera A	Quote: \$	\$			