

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 includes preventive immunizations, screenings, exams**			This is an HSA-compatible plan. You will pay \$0 after meeting the deductible.
Primary Care Physician Visit	Co-pay \$30	Co-pay \$40	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	
Specialist Visit	Co-pay \$75	Co-pay \$100	Deductible/ 40% Coinsurance	
Urgent Care Services	Co-pay \$30	Co-pay \$40	Co-pay \$40	
Lab and X-Ray (Diagnostic Test)	Deductible/ 30% Coinsurance	Deductible/ 40% Coinsurance	Deductible/ 40% 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 Disorder				
Outpatient Services	Co-pay \$30	Co-pay \$40	Co-pay \$40/visit for first three visits then subject to Deductible/ Coinsurance	
Inpatient Services	Deductible and coinsurance apply for all plans.			
Pharmacy Benefits				
Pharmacy Deductible - Individual	\$50	\$50	\$50	\$0
- Family	\$100	\$100	\$100	\$0
Tier 1: Preventive Medications	\$0	\$0	\$0	Tier 1 = \$0 You will pay \$0 after meeting the medical deductible.
Tier 2: Preferred Generics	\$10	\$10	\$10	
Tier 3: Non-Preferred Generics	\$30	\$30	\$30	
Tier 4: Preferred Brands	\$50	\$50	\$75	
Tier 5: Non-Preferred Brands	\$100	\$150	\$150	
Tier 6: Specialty Medications (brand and generic)	30% Coinsurance/ \$250 maximum	40% Coinsurance/ \$250 maximum	40% Coinsurance/ \$250 maximum	
	Silver	Silver	Bronze	Bronze
Quote:	\$ _____	\$ _____	\$ _____	\$ _____



Off Exchange – Stanley County

	Avera 2500	Avera 6250*
Deductible		
Individual	\$2,500	\$6,250
Family	\$5,000	\$12,500
Coinsurance		
	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 immunizations, screenings, exams**	<p>This is an HSA-compatible plan.</p> <p>You will pay \$0 after meeting the deductible.</p>
Primary Care Physician Visit	Co-pay \$30	
Specialist Visit	Co-pay \$75	
Urgent Care Services	Co-pay \$30	
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 Disorder		
Outpatient Services	Co-pay \$30	
Inpatient Services	Deductible and coinsurance apply for all plans.	
Pharmacy Benefits		
Pharmacy Deductible - Individual	\$50	\$0
- Family	\$100	\$0
Tier 1: Preventive Medications	\$0	<p>Tier 1 = \$0</p> <p>You will pay \$0 after meeting the medical deductible.</p>
Tier 2: Preferred Generics	\$10	
Tier 3: Non-Preferred Generics	\$30	
Tier 4: Preferred Brands	\$50	
Tier 5: Non-Preferred Brands	\$100	
Tier 6: Specialty Medications (brand and generic)	30% Coinsurance/ \$250 maximum	
	Silver	Bronze
Quote:	\$ _____	\$ _____



Quote:

\$ _____

\$ _____