

Traditional Plans

Application ID # _____

	Avera 1750	Avera 3000	Avera 3500
Medical Deductible			
Individual	\$1,750	\$3,000	\$3,500
Family	\$3,500	\$6,000	\$7,000
Coinsurance			
	30%	30%	40%
Out-of-Pocket Maximum			
Individual	\$6,500	\$8,700	\$8,500
Family	\$13,000	\$17,400	\$17,000
Medical Benefits			
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*		
Primary Care Physician Visit	Co-pay \$25	Medical Deductible/ 30% Coinsurance	Co-pay \$50
Urgent Care Services			
Chiropractic Visit †			
Specialist Visit	Co-pay \$50		Co-pay \$80
Lab and X-Ray (Diagnostic Test)	Medical Deductible/ 30% Coinsurance		
Hospital Services			
Emergency Services			
Maternity Services			
Pediatric Vision Services ††	No cost to you		
Pediatric Dental Services ††			
AveraNow			
Mental Health and Substance Use Disorder			
Outpatient Services	Co-pay \$25	Medical Deductible/ 30% Coinsurance	Co-pay \$50
Inpatient Services	Medical Deductible/ 30% Coinsurance		Medical Deductible/ 40% Coinsurance
Pharmacy Benefits			
Pharmacy Deductible - Individual	\$0	\$0	\$0
- Family	\$0	\$0	\$0
Tier 1: Preventive Drugs	\$0	\$0	\$0
Tier 2: Preferred Generics	\$0	Medical Deductible/ 30% Coinsurance	\$0
Tier 3: Non-Preferred Generics	\$30		\$30
Tier 4: Preferred Brands	\$50		\$50
Tier 5: Non-Preferred Brands	\$125		\$125
Tier 6: Specialty Drugs (Brand and Generic)	30% Coinsurance		30% Coinsurance
	Gold	Silver	Silver
Quote:	\$ _____	\$ _____	\$ _____

*Examples include gynecological exam, screening mammography, well-child care and newborn care. Limitations do apply. For a detailed listing, visit AveraHealthPlans.com.
 † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.

Traditional Plans

Application ID # _____

	Avera 4500 HSA-Eligible HDHP****	Avera 7000	Avera 6800
Medical Deductible			
Individual	\$4,500	\$7,000	\$6,800
Family	\$9,000	\$14,000	\$13,600
Coinsurance			
	0%	30%	50%
Out-of-Pocket Maximum			
Individual	\$4,500	\$8,500	\$8,700
Family	\$9,000	\$17,000	\$17,400
Medical Benefits			
Preventive Care Services	No cost to member. This includes preventive immunizations, screenings, exams*		
Primary Care Physician Visit	This is an HSA-compatible plan. Please note: Cost Share Reduction plans may not qualify You will pay \$0 after meeting the Medical Deductible	Co-pay \$20	Co-pay \$50/visit*** for the first 2 visits, then subject to Medical Deductible/ 50% Coinsurance
Urgent Care Services			
Chiropractic Visit †		Medical Deductible/ 30% Coinsurance	Medical Deductible/ 50% Coinsurance
Specialist Visit			
Lab and X-Ray (Diagnostic Test)			
Hospital Services		No cost to you	No cost to you
Emergency Services			
Maternity Services			
Pediatric Vision Services ††	No cost to you	No cost to you	
Pediatric Dental Services ††			
AveraNow	You will pay \$0 after meeting the Medical Deductible	No cost to you	
Mental Health and Substance Use Disorder			
Outpatient Services	You will pay \$0 after meeting the Medical Deductible	Co-pay \$20	Co-pay \$50/visit*** for the first 2 visits, then subject to Medical Deductible/ 50% Coinsurance
Inpatient Services		Medical Deductible/ 30% Coinsurance	Medical Deductible/ 50% Coinsurance
Pharmacy Benefits			
Pharmacy Deductible - Individual	\$0	\$0	\$100
- Family	\$0	\$0	\$200
Tier 1: Preventive Drugs	\$0	\$0	\$0
Tier 2: Preferred Generics	You will pay \$0 after meeting the Medical Deductible	Medical Deductible/ 30% Coinsurance	\$0
Tier 3: Non-Preferred Generics			\$50
Tier 4: Preferred Brands			\$100
Tier 5: Non-Preferred Brands			\$150
Tier 6: Specialty Drugs (Brand and Generic)			30% Coinsurance
	Silver	Silver	Expanded Bronze
Quote:	\$ _____	\$ _____	\$ _____

*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 2 visit benefit total. It is not 2 visits per coverage category.
 ****These plans are considered High Deductible Health Plans (HDHP) that can be paired with a Health Savings Account (HSA).
 † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.

Traditional Plans

Application ID # _____

	Avera 6850 HSA-Eligible HDHP****	Avera 8000	Avera 8700**
Medical Deductible			
Individual	\$6,850	\$8,000	\$8,700
Family	\$13,700	\$16,000	\$17,400
Coinsurance			
	0%	50%	0%
Out-of-Pocket Maximum			
Individual	\$6,850	\$8,700	\$8,700
Family	\$13,700	\$17,400	\$17,400
Medical Benefits			
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*		
Primary Care Physician Visit	This is an HSA-compatible plan. Member will pay \$0 after meeting the Medical Deductible	Co-pay \$20	Co-pay \$0/visit***** for the first 3 visits, then subject to Medical Deductible/ 0% Coinsurance
Urgent Care Services			
Chiropractic Visit †			
Specialist Visit		Medical Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Medical Deductible
Lab and X-Ray (Diagnostic Test)			
Hospital Services			
Emergency Services			
Maternity Services	No cost to you	No cost to you	
Pediatric Vision Services ††			
Pediatric Dental Services ††			
AveraNow	You will pay \$0 after meeting the Medical Deductible		
Mental Health and Substance Use Disorder			
Outpatient Services	You will pay \$0 after meeting the Medical Deductible	Co-pay \$20	Co-pay \$0/visit***** for the first 3 visits, then subject to Medical Deductible/ 0% Coinsurance
Inpatient Services		Medical Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Medical Deductible
Pharmacy Benefits			
Pharmacy Deductible - Individual	\$0	\$0	\$0
- Family	\$0	\$0	\$0
Tier 1: Preventive Drugs	\$0	\$0	\$0
Tier 2: Preferred Generics	You will pay \$0 after meeting the Medical Deductible	Medical Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Medical Deductible
Tier 3: Non-Preferred Generics			
Tier 4: Preferred Brands			
Tier 5: Non-Preferred Brands			
Tier 6: Specialty Drugs (Brand and Generic)			
	Expanded Bronze	Expanded Bronze	Catastrophic
Quote:	\$ _____	\$ _____	\$ _____

*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.
 ****These plans are considered High Deductible Health Plans (HDHP) that can be paired with a Health Savings Account (HSA).
 *****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.
 † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.

Additional plans for residents in Brown, Lincoln and Minnehaha counties only

Application ID # _____

	Avera Preferred 1750		Avera Preferred 3000		
	Level 1	Level 2	Level 1	Level 2	
Medical Deductible					
Individual	\$1,750	\$3,000	\$3,000	\$3,000	
Family	\$3,500	\$6,000	\$6,000	\$6,000	
Coinsurance					
	30%	40%	30%	40%	
Out-of-Pocket Maximum					
Individual	\$5,000	\$6,000	\$8,700	\$8,700	
Family	\$10,000	\$12,000	\$17,400	\$17,400	
Medical Benefits					
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*				
Primary Care Physician Visit	Co-pay \$20	Co-pay \$60	Medical Deductible/ 30% Coinsurance	Medical Deductible/ 40% Coinsurance	
Urgent Care Services	Co-pay \$0				
Chiropractic Visit †	Co-pay \$20	Co-pay \$20		Medical Deductible/ 30% Coinsurance	
Specialist Visit	Co-pay \$40	Co-pay \$100		Medical Deductible/ 40% Coinsurance	
Lab and X-Ray (Diagnostic Test)	Co-pay \$0	Medical Deductible/ 40% Coinsurance			
Hospital Services	Medical Deductible/ 30% Coinsurance	Medical Deductible/ 30% Coinsurance		Medical Deductible/ 30% Coinsurance	
Emergency Services		Medical Deductible/ 40% Coinsurance		Medical Deductible/ 40% Coinsurance	
Maternity Services					
Pediatric Vision Services ††	No cost to you				
Pediatric Dental Services ††					
AveraNow					
Mental Health and Substance Use Disorder					
Outpatient Services	Co-pay \$20	Co-pay \$60	Medical Deductible/ 30% Coinsurance	Medical Deductible/ 40% Coinsurance	
Inpatient Services	Medical Deductible/ 30% Coinsurance	Medical Deductible/ 40% Coinsurance			
Pharmacy Benefits					
Pharmacy Deductible - Individual	\$0		\$0		
- Family	\$0		\$0		
Tier 1: Preventive Drugs	\$0		\$0		
Tier 2: Preferred Generics	\$0		Medical Deductible/30% Coinsurance		
Tier 3: Non-Preferred Generics	\$30				
Tier 4: Preferred Brands	\$50				
Tier 5: Non-Preferred Brands	\$125				
Tier 6: Specialty Drugs (Brand and Generic)	30% Coinsurance				
	Gold		Silver		
Quote:	\$ _____		\$ _____		

*Examples include gynecological exam, screening mammography, well-child care and newborn care. Limitations do apply. For a detailed listing, visit AveraHealthPlans.com.
 † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.

Additional plans for residents in Brown, Lincoln and Minnehaha counties only

Application ID # _____

	Avera Preferred 3500		Avera Preferred 7000	
	Level 1	Level 2	Level 1	Level 2
Medical Deductible				
Individual	\$3,500	\$3,500	\$7,000	\$7,000
Family	\$7,000	\$7,000	\$14,000	\$14,000
Coinsurance				
	40%	50%	30%	40%
Out-of-Pocket Maximum				
Individual	\$8,500	\$8,700	\$8,000	\$8,700
Family	\$17,000	\$17,400	\$16,000	\$17,400
Medical Benefits				
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*			
Primary Care Physician Visit	Co-pay \$35	Co-pay \$80	Co-pay \$15	Co-pay \$40
Urgent Care Services	Co-pay \$0		Co-pay \$0	
Chiropractic Visit †	Co-pay \$35	Co-pay \$35	Co-pay \$15	Co-pay \$15
Specialist Visit	Co-pay \$60	Medical Deductible/ 50% Coinsurance	Co-pay \$40	Medical Deductible/ 40% Coinsurance
Lab and X-Ray (Diagnostic Test)	Medical Deductible/ 40% Coinsurance		Medical Deductible/ 30% Coinsurance	
Hospital Services				
Emergency Services		Medical Deductible/ 50% Coinsurance		Medical Deductible/ 40% Coinsurance
Maternity Services				Medical Deductible/ 40% Coinsurance
Pediatric Vision Services ††	No cost to you			
Pediatric Dental Services ††				
AveraNow				
Mental Health and Substance Use Disorder				
Outpatient Services	Co-pay \$35	Co-pay \$80	Co-pay \$15	Co-pay \$40
Inpatient Services	Medical Deductible/ 40% Coinsurance	Medical Deductible/ 50% Coinsurance	Medical Deductible/ 30% Coinsurance	Medical Deductible/ 40% Coinsurance
Pharmacy Benefits				
Pharmacy Deductible - Individual	\$0		\$0	
- Family	\$0		\$0	
Tier 1: Preventive Drugs	\$0		\$0	
Tier 2: Preferred Generics	\$0		Medical Deductible/30% Coinsurance	
Tier 3: Non-Preferred Generics	\$30			
Tier 4: Preferred Brands	\$50			
Tier 5: Non-Preferred Brands	\$125			
Tier 6: Specialty Drugs (Brand and Generic)	30% Coinsurance			
	Silver		Silver	
Quote:	\$ _____		\$ _____	

*Examples include gynecological exam, screening mammography, well-child care and newborn care. Limitations do apply. For a detailed listing, visit AveraHealthPlans.com.
 † Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.

Additional plans for residents in Brown, Lincoln and Minnehaha counties only

Application ID # _____

	Avera Preferred 6800		Avera Preferred 6850 HSA Eligible HDHP****	
	Level 1	Level 2	Level 1	Level 2
Medical Deductible				
Individual	\$6,800	\$7,000	\$6,850	\$7,050
Family	\$13,600	\$14,000	\$13,700	\$14,100
Coinsurance				
	50%	50%	0%	0%
Out-of-Pocket Maximum				
Individual	\$8,700	\$8,700	\$6,850	\$7,050
Family	\$17,400	\$17,400	\$13,700	\$14,100
Medical Benefits				
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*			
Primary Care Physician Visit	Co-pay \$50/visit*** for the first 2 visits, then subject to Medical Deductible/ 50% Coinsurance	Medical Deductible/ 50% Coinsurance	This is an HSA-compatible plan. You will pay \$0 after meeting the Medical Deductible	
Urgent Care Services		Co-pay \$50/visit*** for the first 2 visits, then subject to Medical Deductible/ 50% Coinsurance		
Chiropractic Visit †	Medical Deductible/ 50% Coinsurance			
Specialist Visit				
Lab and X-Ray (Diagnostic Test)				
Hospital Services				
Emergency Services				
Maternity Services	No cost to you			
Pediatric Vision Services ††				
Pediatric Dental Services ††				
AveraNow			You will pay \$0 after meeting the Medical Deductible	
Mental Health and Substance Use Disorder				
Outpatient Services	Co-pay \$50/visit*** for the first 2 visits, then subject to Medical Deductible/ 50% Coinsurance	Medical Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Medical Deductible	
Inpatient Services	Medical Deductible/ 50% Coinsurance			
Pharmacy Benefits				
Pharmacy Deductible - Individual	\$100	\$0		
- Family	\$200	\$0		
Tier 1: Preventive Drugs	\$0	\$0		
Tier 2: Preferred Generics	\$0	You will pay \$0 after meeting the Medical Deductible		
Tier 3: Non-Preferred Generics	\$50			
Tier 4: Preferred Brands	\$100			
Tier 5: Non-Preferred Brands	\$150			
Tier 6: Specialty Drugs (Brand and Generic)	30% Coinsurance			
	Expanded Bronze		Expanded Bronze	
Quote:	\$ _____		\$ _____	

*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 2 visit benefit total. It is not 2 visits per coverage category.
 ****These plans are considered High Deductible Health Plans (HDHP) that can be paired with a Health Savings Account (HSA).
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Additional plans for residents in Brown, Lincoln and Minnehaha counties only

Application ID # _____

	Avera Preferred 8000		Avera Focused 8700**
	Level 1	Level 2	In Network
Medical Deductible			
Individual	\$8,000	\$8,500	\$8,700
Family	\$16,000	\$17,000	\$17,400
Coinsurance			
	40%	50%	0%
Out-of-Pocket Maximum			
Individual	\$8,700	\$8,700	\$8,700
Family	\$17,400	\$17,400	\$17,400
Medical Benefits			
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams*		
Primary Care Physician Visit	Co-pay \$20	Medical Deductible/ 50% Coinsurance	Co-pay \$0/visit***** for the first 3 visits, then subject to Medical Deductible/ 0% Coinsurance
Urgent Care Services	Co-pay \$0		
Chiropractic Visit †	Co-pay \$20	Co-pay \$20	
Specialist Visit	Medical Deductible/ 40% Coinsurance	Medical Deductible/ 50% Coinsurance	You will pay \$0 after meeting the Medical Deductible
Lab and X-Ray (Diagnostic Test)			
Hospital Services			
Emergency Services		Medical Deductible/ 40% Coinsurance	
Maternity Services		Medical Deductible/ 50% Coinsurance	
Pediatric Vision Services ††	No cost to you		
Pediatric Dental Services ††			
AveraNow			
Mental Health and Substance Use Disorder			
Outpatient Services	Co-pay \$20	Medical Deductible/ 50% Coinsurance	Co-pay \$0/visit***** for the first 3 visits, then subject to Medical Deductible/ 0% Coinsurance
Inpatient Services	Medical Deductible/ 40% Coinsurance		You will pay \$0 after meeting the Medical Deductible
Pharmacy Benefits			
Pharmacy Deductible - Individual		\$0	\$0
- Family		\$0	\$0
Tier 1: Preventive Drugs		\$0	\$0
Tier 2: Preferred Generics	Medical Deductible/ 40% Coinsurance		You will pay \$0 after meeting the Medical Deductible
Tier 3: Non-Preferred Generics			
Tier 4: Preferred Brands			
Tier 5: Non-Preferred Brands			
Tier 6: Specialty Drugs (Brand and Generic)			
	Expanded Bronze		Catastrophic
Quote:	\$ _____		\$ _____

*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.

*****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.

† Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization. †† Basic services only. See SBC for details.