

Students in Brown, Lincoln and Minnehaha counties only	Avera Preferred 2750		Avera Preferred 3500		Avera Preferred 6000			
	Level 1	Level 2	Level 1	Level 2	Level 1	Level 2		
Deductible								
Individual	\$2,750	\$2,750	\$3,500	\$3,500	\$6,000	\$7,500		
Family	\$5,500	\$5,500	\$7,000	\$7,000	\$12,000	\$15,000		
Coinsurance								
	30%	40%	40%	50%	50%	50%		
Out-of-Pocket Maximum								
Individual	\$7,500	\$7,500	\$7,500	\$7,500	\$8,150	\$8,150		
Family	\$15,000	\$15,000	\$15,000	\$15,000	\$16,300	\$16,300		
Medical Benefits								
Preventive Care Services	No cost to you. This includes preventive immunizations, screenings, exams**							
Primary Care Physician Visit	Deductible/ 30% Coinsurance	Deductible/ 40% Coinsurance	Co-pay \$50	Co-pay \$75	Co-pay \$50/visit *** for first 3 visits then subject to Deductible/ 50% Coinsurance	Deductible/ 50% Coinsurance		
Specialist Visit			Co-pay \$80	Co-pay \$100	Deductible/ 50% Coinsurance			
Urgent Care Services			Co-pay \$50	Co-pay \$75	Co-pay \$50/visit *** for first 3 visits then subject to Deductible/ 50% Coinsurance			
Lab and X-Ray (Diagnostic Test)			Deductible/ 40% Coinsurance	Deductible/ 50% Coinsurance	Deductible/ 50% Coinsurance			
Hospital Services		Deductible/ 40% Coinsurance		Deductible/ 40% Coinsurance		Deductible/ 50% Coinsurance		
Emergency Services							Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Maternity Services								
Pediatric Vision Services	Included with all plans							
Pediatric Dental Services								
Chiropractor Visit †	Deductible/ 30% Coinsurance	Deductible/ 30% Coinsurance	Co-pay \$50	Co-pay \$50	Co-pay \$50/visit *** for first 3 visits then subject to Deductible/ 50% Coinsurance	Co-pay \$50/visit *** for first 3 visits then subject to Deductible/ 50% Coinsurance		
AveraNow	No cost to the member							
Mental Health and Substance Use Disorder								
Outpatient Services	Deductible/ 30% Coinsurance	Deductible/ 40% Coinsurance	Co-pay \$50	Co-pay \$75	Co-pay \$50/visit*** for first 3 visits then subject to Deductible/ 50% Coinsurance	Deductible/ 50% Coinsurance		
Inpatient Services			Deductible/ 40% Coinsurance	Deductible/ 50% Coinsurance	Deductible/ 50% Coinsurance			
Pharmacy Benefits								
Pharmacy Deductible - Individual	\$0		\$50		\$50			
- Family	\$0		\$100		\$100			
Tier 1: Preventive Drugs	\$0		\$0		\$0			
Tier 2: Preferred Generics	Medical Deductible/ 30% Coinsurance		\$10		\$15			
Tier 3: Non-Preferred Generics			\$30		\$35			
Tier 4: Preferred Brands			\$50		\$75			
Tier 5: Non-Preferred Brands			\$100		\$150			
Tier 6: Specialty Drugs (brand and generic)			40% Coinsurance/ \$250 maximum		40% Coinsurance/ \$250 maximum			
Quote:	Silver		Silver		Bronze			
	\$ _____		\$ _____		\$ _____			