**Important Questions** | **Answers** | **Why this Matters**
--- | --- | ---
What is the overall **deductible**? | In-Network $8,150 Individual or $16,300 Family. Out-of-Network $10,000 Individual or $20,000 Family. Does not apply to pharmacy. **Co-pays** do not count toward any **deductibles**. | Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.

Are there services covered before you meet your **deductible**? | Yes. | This **plan** covers some items and services even if you haven’t yet met the **deductible** amount. But a copayment or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

Are there other **deductibles** for specific services? | No. | You don’t have to meet **deductibles** for specific services.

What is the **out-of-pocket limit** for this **plan**? | In-Network $8,150 Individual or $16,300 Family and there is no **out-of-pocket limit** for out-of-network. | The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own individual **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.

What is not included in the **out-of-pocket limit**? | **Premiums**, **balance billed** charges, and health care services this **plan** does not cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

Will you pay less if you use a **network provider**? | Yes. See [www.AveraHealthPlans.com](http://www.AveraHealthPlans.com) or call 1(888) 322-2115 for a list of network providers. | This **plan** uses a provider **network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider’s charge and what your **plan** pays (balance billing). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

Do you need a **referral** to see a **specialist**? | No. | You can see the **specialist** you choose without a **referral**.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td><strong>Primary care</strong> visit to treat an injury or illness</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Maximum of 3 visits per year for $0 co-pay. After 3 visits, subject to deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td><strong>Chiropractic</strong> visit</td>
<td>0% coinsurance after deductible</td>
<td>Not covered</td>
<td>Maximum of 3 visits per year for $0 co-pay. After 3 visits, subject to deductible. Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>$0</td>
<td>Not covered</td>
<td>Age and frequency limitations may apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging</strong> (CT/PET scans, MRIs)</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Some imaging requires preauthorization. Major lab and X-ray services may include PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine and MRA.</td>
</tr>
<tr>
<td>Common Medical Event</td>
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</tr>
<tr>
<td>----------------------</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1: Preventive medications</td>
<td>$0 <strong>co-pay</strong> for 30-day supply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred Generics and some brand medications</td>
<td>0% <strong>coinsurance</strong> for 30-day supply after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>
|                      | Tier 3: Non-preferred generics and some brand medications | 0% **coinsurance** for 30-day supply after deductible | Not covered | Certain drugs require **preauthorization**. The **preauthorization** for the drug must be approved before the drug will be covered.  
|                      | Tier 4: Preferred brand medications | 0% **coinsurance** for 30-day supply after deductible | Not covered |  
|                      | Tier 5: Non-preferred brand medications | 0% **coinsurance** for 30-day supply after deductible | Not covered |  
|                      | Tier 6: Specialty medications, brand and generic | 0% **coinsurance** for 30-day supply after deductible | Not covered |  
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% **coinsurance** after deductible | 40% **coinsurance** after deductible |  
|                      | Physician/surgeon fees | 0% **coinsurance** after deductible | 40% **coinsurance** after deductible |  
| **If you need immediate medical attention** | **Emergency room care** | 0% **coinsurance** after deductible | 0% **coinsurance** after deductible |  
|                      | **Emergency medical transportation** | 0% **coinsurance** after deductible | 0% **coinsurance** after deductible | **Preauthorization** for non-emergency transportation. No coverage for services without **preauthorization**.  
|                      | **Urgent care** | 0% **coinsurance** after deductible | 40% **coinsurance** after deductible | Maximum of 3 visits per year for $0 **co-pay**. After 3 visits, subject to **deductible**. For out-of-network urgent care visits, you may contact the plan to determine if your visit qualifies for in-network benefits.  
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% **coinsurance** after deductible | 40% **coinsurance** after deductible | **Preauthorization** required. No coverage for services without **preauthorization**.  
|                      | Physician/surgeon fee | 0% **coinsurance** after deductible | 40% **coinsurance** after deductible |  

More information about **prescription drug coverage** is available at [www.averawebplace/drug-formulary](http://www.averawebplace/drug-formulary).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office: 0% coinsurance per visit after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Maximum of 3 visits per year for $0 copay. After 3 visits, subject to deductible. Services other than therapy performed in the office or any service at a facility: 0% coinsurance after deductible.</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Preauthorization required. No coverage for services without preauthorization.</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>60-visit limit per plan year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>0% coinsurance per visit after deductible</td>
<td>40% coinsurance after deductible</td>
<td>Maximum of 3 visits per year for $0 copay. After 3 visits, subject to deductible. Preauthorization required after 30 visits per plan year for each therapy: physical, occupational and speech. No coverage for services without preauthorization. Cardiac and pulmonary rehab services from participating providers are 0% coinsurance and have a 36-visit maximum per plan year.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>0% coinsurance per visit after deductible</td>
<td>40% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>100-day confinement limit for services from participating providers. 60-day confinement limit for services from non-participating providers. Same confinement limit if readmitted with same diagnosis within 60 days.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use a Participating Provider</td>
<td>Your Cost If You Use a Non-Participating Provider</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special needs</td>
<td>Durable medical equipment</td>
<td>0% coinsurance after deductible</td>
<td>Not covered</td>
<td>Certain durable medical equipment require preauthorization. No coverage for services without preauthorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>0% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
<td>185-day limit per plan year</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$0</td>
<td>Not covered</td>
<td>One diagnostic exam per calendar year for children under the age of 19 from a VSP provider. Call 1-800-877-7195 or visit VSP.com to find a participating vision provider.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>$0</td>
<td>Not covered</td>
<td>Frames from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit VSP.com to find a participating vision provider.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>$0</td>
<td>Not covered</td>
<td>Preventive exam every 6 months for children under age of 19. Refer to the Pediatric Dental Addendum for additional coverage details.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Weight loss program
- Non-emergency care when traveling outside the United States

**Other Covered Services** (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery if preauthorization requirements are met
- Chiropractic care if provided by a participating provider
- Private-duty nursing
- Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease
- Medically-indicated termination of pregnancy when necessary to save the life of the mother
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebssa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-888-322-2115, Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebssa/healthreform or the South Dakota Division of Insurance at 605-773-3563.

Does this Coverage Provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-322-2115.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-322-2115.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-888-322-2115.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
AveraHealthPlans.com

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **Peg is Having a Baby**
  - The plan’s overall deductible: $8,150
  - Specialist copayment: 0%
  - Hospital (facility) coinsurance: 0%
  - Other coinsurance: 0%

  This EXAMPLE event includes services like:
  - Specialist office visits (prenatal care)
  - Childbirth/Delivery Professional Services
  - Childbirth/Delivery Facility Services
  - Diagnostic tests (ultrasounds and blood work)
  - Specialist visit (anesthesia)

  Total Example Cost: $12,700

  In this example, Peg would pay:
  - Cost Sharing
    - Deductibles: $8,150
    - Copayments: $0
    - Coinsurance: $0
  - What isn’t covered: $100
  - The total Peg would pay is: $8,250

- **Managing Joe’s type 2 Diabetes**
  - The plan’s overall deductible: $8,150
  - Specialist copayment: 0%
  - Hospital (facility) coinsurance: 0%
  - Other coinsurance: 0%

  This EXAMPLE event includes services like:
  - Primary care physician office visits (including disease education)
  - Diagnostic tests (blood work)
  - Prescription drugs
  - Durable medical equipment (glucose meter)

  Total Example Cost: $7,400

  In this example, Joe would pay:
  - Cost Sharing
    - Deductibles: $8,150
    - Copayments: $0
    - Coinsurance: $0
  - What isn’t covered: $100
  - The total Joe would pay is: $8,250

- **Mia’s Simple Fracture**
  - The plan’s overall deductible: $8,150
  - Specialist copayment: 0%
  - Hospital (facility) coinsurance: 0%
  - Other coinsurance: 0%

  This EXAMPLE event includes services like:
  - Emergency room care (including medical supplies)
  - Diagnostic test (x-ray)
  - Durable medical equipment (crutches)
  - Rehabilitation services (physical therapy)

  Total Example Cost: $1,900

  In this example, Mia would pay:
  - Cost Sharing
    - Deductibles: $1,900
    - Copayments: $0
    - Coinsurance: $0
  - What isn’t covered: $0
  - The total Mia would pay is: $1,900

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.