



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.AveraHealthPlans.com or call 1-888-322-2115. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-322-2115 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | In-Network: \$5,500 Individual or \$11,000 Family. Out-of-Network: \$15,000 Individual or \$30,000 Family. Does not apply to pharmacy. Copays 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/ . |
| 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: \$10,600 Individual / \$21,200 Family. Out-of-Network: \$30,000 Individual / \$60,000 Family. | 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 out-of-pocket limits 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 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 . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge for the first 5 visits, then \$50 copay per visit | 50% coinsurance after deductible | Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation, or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$50 copay . |
| | Specialist visit | \$100 copay per visit | 50% coinsurance after deductible | None |
| | Preventive care/screening/immunization | No charge | Not covered | 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. |
| If you have a test | Diagnostic test (x-ray, blood work, ultrasound) | \$50 copay per service | 50% coinsurance after deductible | All labs are subject to normal plan benefits, with an exception for the following labs, which are covered* up to twice per plan year at \$30 copay** Labs: Comprehensive Metabolic Panel, Complete Blood Count, Hemoglobin A1c, Lipid (Cholesterol) Panel, Thyroid Labs (TSH/Free T4). *Preventive coverage will apply before copay; after copay limits are exhausted, labs will pay at deductible/coinsurance. **Copay will apply regardless of diagnosis. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance after deductible | 50% coinsurance after deductible | Some imaging requires preauthorization . Major lab and X-ray services may include PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine, and MRA. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.averahealthplans.com*

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.averahealthplans.com/insurance/find-a-prescription-drug/ | Tier 1: Preventive medications | No charge for 30-day supply | Not covered | Refer to the 2026 Avera Choice Plus Drug List to determine the tier that applies to a covered drug. Certain drugs require preauthorization . The preauthorization for the drug must be approved before the drug will be covered. |
| | Tier 2: Generic medications | \$15 copay for 30-day supply | Not covered | |
| | Tier 3: Preferred brand medications | \$50 copay for 30-day supply | Not covered | |
| | Tier 4: Non-preferred brand medications | \$150 copay for 30-day supply | Not covered | |
| | Tier 5: Specialty value medications | \$12 copay for 30-day supply | Not covered | |
| | Tier 6: Specialty medications | 30% coinsurance after medical deductible for 30-day supply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance after deductible | 50% coinsurance after deductible | None |
| | Physician/surgeon fees | 50% coinsurance after deductible | 50% coinsurance after deductible | None |
| If you need immediate medical attention | Emergency room care | \$1,250 copay | \$1,250 copay | Copay waived if admitted. |
| | Emergency medical transportation | 50% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization for non-emergency transportation. No coverage for services without preauthorization . |
| | Urgent care | \$50 copay per visit | 50% coinsurance after deductible | In-network benefit for services outside of service area. When using Out-of-Network Provider inside service area, you may contact the plan to determine if your visit qualifies for in-network benefits. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization required. No coverage for services without preauthorization . |
| | Physician/surgeon fees | 50% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge for the first 5 visits, then \$50 copay per therapy visit | 50% coinsurance after deductible | Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation, or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$50 copay . Services other than therapy performed in the office or any service at a facility: 50% coinsurance . Preauthorization required. No coverage for services without preauthorization . |
| | Inpatient services | 50% coinsurance after deductible | 50% coinsurance after deductible | |
| If you are pregnant | Office visits | 50% coinsurance after deductible | 50% coinsurance after deductible | 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). |
| | Childbirth/delivery professional services | 50% coinsurance after deductible | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | 50% coinsurance after deductible | 50% coinsurance after deductible | |
| If you need help recovering or have other special health needs | Home health care | 50% coinsurance after deductible | 50% coinsurance after deductible | One visit equals a maximum of 4 hours, including private duty nursing. |
| | Rehabilitation services | No charge for the first 5 visits, then \$50 copay per visit | 50% coinsurance after deductible | Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation, or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$50 copay . Cardiac and pulmonary rehab services from participating providers are 50% coinsurance and have a 36-visit maximum per plan year. |
| | Habilitation services | No charge for the first 5 visits, then \$50 copay per visit | 50% coinsurance after deductible | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.averahealthplans.com*

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Skilled nursing care | 50% coinsurance after deductible | 50% coinsurance after deductible | 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. |
| | Durable medical equipment | 50% coinsurance after deductible | Not covered | Certain durable medical equipment require preauthorization . No coverage for services without preauthorization . |
| | Hospice services | 50% coinsurance after deductible | 50% coinsurance after deductible | 185-day limit per plan year |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | 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. |
| | Children's glasses | No charge | Not covered | One frame from the designated pediatric eyewear collection is covered. Call 1-800-877-7195 or visit VSP.com to find a participating vision provider. |
| | Children's dental check-up | No charge | Not covered | Preventive exam every 6 months for children under age of 19. Refer to the Pediatric Dental Addendum for additional coverage details. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.averahealthplans.com*

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---|---|--|
| <ul style="list-style-type: none">• Abortion (except when the life of the mother is endangered)• Acupuncture• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Non-emergency care when traveling outside the United States | <ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Weight loss program |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• Bariatric surgery if preauthorization requirements are met• Employee Assistance Program | <ul style="list-style-type: none">• Private-duty nursing | <ul style="list-style-type: none">• Chiropractic care if provided by a participating provider |

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/ebsa, 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/ebsa/healthreform or the Iowa Insurance Division at 1-877-955-1212. Additionally, a consumer assistance program can help you file your appeal. Contact the Iowa Bureau at 1-877-955-1212. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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, kwijigo holne' 1-888-322-2115.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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 | \$5,500 |
| Copayments | \$500 |
| Coinsurance | \$3,000 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$9,060 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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 \$5,600

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$1,500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,320 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,500
- [Specialist copayment](#) \$100
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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 \$2,800

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,300 |
| Copayments | \$1,200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,500 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Customer Care team at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
 Avera Health Plans
 5300 S Broadband Ln
 Sioux Falls, SD 57108-2221
 Fax 1-800-269-8561
 Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services
 200 Independence Avenue SW Room 509F, HHH Building
 Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Getting Help in Other Languages

- **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- **LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- **XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- **注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113)。
- **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم 1-800-877-1113).
- **ໂບດຊາບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-888-322-2115 (TTY: 1-800-877-1113).
- **ဟံသုတ်ဝါသ:** နမူကတိ၊ ကညီ ကျိအယိ၊ နမူကတိ၊ ကျိအတိ၊ မဟေလော တလက်ဘူင်လက်စု၊ နိတမံဘေဉ်သုနုင်လိ၊ ဝံ 1-888-322-2115 (TTY: 1-800-877-1113).
- **ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-888-322-2115 (TTY: 1-800-877-1113). 번으로 전화해 주십시오.
- **ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዎል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877- 1113).
- **OBAVJEŠTENJE:** Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- **ပြည်တွင်း:** ပြီးလိင်သာမန်စီယာယ နာမာဉ်ဦး၊ လောကီဗွယ်ဗွယ်ကနာမာ ညော့မိဒဗီဒဗီလူလူ နီကဗမာဒလံဂံပံဂီမူကု ဗွာ ဗွာမံဗွာ ၄ 1-888-322-2115 (TTY: 1-800-877-1113).