



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: \$2,500 Individual or \$5,000 Family. Out-of-Network: \$10,000 Individual or \$20,000 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: \$6,650 Individual / \$13,300 Family. Out-of-Network: \$20,000 Individual / \$40,000 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	\$25 copay per visit	40% coinsurance after deductible	None
	Specialist visit	\$75 copay per visit	40% 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)	\$25 copay per service	40% coinsurance after deductible	Copay applies when diagnostic test is performed in an office setting. Coinsurance applies when lab or X-ray are sent out or performed in a hospital, surgical center, or outpatient facility.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	40% 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 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	\$75 copay for 30-day supply	Not covered	
	Tier 5: Specialty value medications	\$10 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)	30% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	\$500 copay	\$500 copay	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Preauthorization for non-emergency transportation. No coverage for services without preauthorization .
	Urgent care	\$25 copay per visit	40% 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)	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required. No coverage for services without preauthorization .
	Physician/surgeon fees	30% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 copay per therapy visit	40% coinsurance after deductible	Services other than therapy performed in the office or any service at a facility: 30% coinsurance .
	Inpatient services	30% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required. No coverage for services without preauthorization .
If you are pregnant	Office visits	30% coinsurance after deductible	40% 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	30% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	40% coinsurance after deductible	

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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 need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	40% coinsurance after deductible	60-visit limit per plan year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.
	Rehabilitation services	\$25 copay per visit	40% coinsurance after deductible	Cardiac and pulmonary rehab services from participating providers are 30% coinsurance and have a 36-visit maximum per plan year.
	Habilitation services	\$25 copay per visit	40% coinsurance after deductible	
	Skilled nursing care	30% coinsurance after deductible	40% 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	30% coinsurance after deductible	Not covered	Certain durable medical equipment require preauthorization . No coverage for services without preauthorization .
	Hospice services	30% coinsurance after deductible	40% 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.

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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](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$400
Coinsurance	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,560

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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

