



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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-888-322-2115 to request a copy.

| Important Questions   | Answers  | Why this Matters  |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | In-Network \$4,000 Individual or \$8,000 Family. Out-of-Network \$5,000 Individual or \$10,000 Family.                                   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a copayment or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. \$50 pharmacy <a href="#">deductible</a> per member or \$100 pharmacy <a href="#">deductible</a> per family.                        | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In-Network \$8,000 Individual or \$16,000 Family. Out-of-Network \$10,000 Individual or \$20,000 Family.                                 | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billed</a> charges, and health care services this <a href="#">plan</a> does not cover.    | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.AveraHealthPlans.com">www.AveraHealthPlans.com</a> or call 1(888) 322-2115 for a list of network providers. | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

| Common Medical Event                                   | Services You May Need   | Your Cost If You Use a Participating Provider    | Your Cost If You Use a Non-Participating Provider | Limitations, Exceptions, & Other Important Information   |
|--|---|--|---|--|
| If you visit a health care provider's office or clinic | <a href="#">Primary care</a> visit to treat an injury or illness          | \$50 <a href="#">co-pay</a> per visit            | 50% <a href="#">coinsurance</a> after deductible  | ---none---   |
|  | <a href="#">Specialist</a> visit  | \$100 <a href="#">co-pay</a> per visit           | 50% <a href="#">coinsurance</a> after deductible  | ---none---   |
|  | Chiropractic visit  | \$50 <a href="#">co-pay</a> per visit            | Not covered                                       | <a href="#">Preauthorization</a> is required after 20 chiropractic visits per <a href="#">plan</a> year. No coverage for services without <a href="#">preauthorization</a> .   |
|  | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization | No charge  | Not covered                                       | Age and frequency limitations may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                       | \$50 <a href="#">co-pay</a> per visit            | 50% <a href="#">coinsurance</a> after deductible  | <a href="#">Co-pay</a> is for minor lab and X-rays. Lab and X-ray performed in a hospital, surgical center or outpatient facility apply to deductible and coinsurance.   |
|  | Imaging (CT/PET scans, MRIs)  | 40% <a href="#">coinsurance</a> after deductible | 50% <a href="#">coinsurance</a> after deductible  | Some imaging requires <a href="#">preauthorization</a> . Major lab and X-ray services may include PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine and MRA.  |

| Common Medical Event  | Services You May Need                                     | Your Cost If You Use a Participating Provider                      | Your Cost If You Use a Non-Participating Provider | Limitations, Exceptions, & Other Important Information   |
|---|---|--|---|--|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avera.org/marketplace/drug-formulary/">www.avera.org/marketplace/drug-formulary/</a> | Tier 1: Preventive medications                            | No charge for 30-day supply  | Not covered                                       | Prescription drugs are subject to a \$50 <a href="#">deductible</a> per member and \$100 <a href="#">deductible</a> per family per calendar year for tiers 2 through 6. Certain drugs require <a href="#">preauthorization</a> . The <a href="#">preauthorization</a> for the drug must be approved before the drug will be covered. |
|   | Tier 2: Preferred Generics and some brand medications     | \$15 <a href="#">co-pay</a> for 30-day supply after deductible     | Not covered                                       |  |
|   | Tier 3: Non-preferred generics and some brand medications | \$15 <a href="#">co-pay</a> for 30-day supply after deductible     | Not covered                                       |  |
|   | Tier 4: Preferred brand medications                       | \$50 <a href="#">co-pay</a> for 30-day supply after deductible     | Not covered                                       |  |
|   | Tier 5: Non-preferred brand medications                   | \$150 <a href="#">co-pay</a> for 30-day supply after deductible    | Not covered                                       |  |
|   | Tier 6: Specialty medications, brand and generic          | 20% <a href="#">coinsurance</a> for 30-day supply after deductible | Not covered                                       |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)            | 40% <a href="#">coinsurance</a> after deductible                   | 50% <a href="#">coinsurance</a> after deductible  | ---none---   |
|   | Physician/surgeon fees                                    | 40% <a href="#">coinsurance</a> after deductible                   | 50% <a href="#">coinsurance</a> after deductible  | ---none---   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                       | 40% <a href="#">coinsurance</a> after deductible                   | 40% <a href="#">coinsurance</a> after deductible  | ---none---   |
|   | <a href="#">Emergency medical transportation</a>          | 40% <a href="#">coinsurance</a> after deductible                   | 40% <a href="#">coinsurance</a> after deductible  | <a href="#">Preauthorization</a> for non-emergency transportation. No coverage for services without <a href="#">preauthorization</a> .   |
|   | <a href="#">Urgent care</a>                               | \$50 <a href="#">co-pay</a> per visit                              | 50% <a href="#">coinsurance</a> after deductible  | For out-of-network <a href="#">urgent care</a> visits, you may contact the <a href="#">plan</a> to determine if your visit qualifies for in-network benefits.  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)                        | 40% <a href="#">coinsurance</a> after deductible                   | 50% <a href="#">coinsurance</a> after deductible  | <a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .   |
|   | Physician/surgeon fee                                     | 40% <a href="#">coinsurance</a> after deductible                   | 50% <a href="#">coinsurance</a> after deductible  |  |

| Common Medical Event   | Services You May Need   | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations, Exceptions, & Other Important Information  |
|--|---|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services   | Office: \$50 <u>co-pay</u> per therapy visit  | 50% <u>coinsurance</u> after deductible           | Services other than therapy performed in the office or any service at a facility: 40% <u>coinsurance</u> after deductible.  |
|  | Inpatient services  | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> after deductible           | <u>Preauthorization</u> required. No coverage for services without <u>preauthorization</u> .  |
|  | Employee Assistance Program   | \$0 per visit                                 | Not Covered                                       | Limit of 3 visits per contract year for mental health and substance use disorder outpatient services combined. For a list of participating providers call 1-800-527-9394.   |
| If you are pregnant  | Office Visits   | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> after deductible           | <u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services   | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> after deductible           |   |
|  | Childbirth/delivery facility services   | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> after deductible           |   |
| If you need help recovering or have other special needs                | <u>Home health care</u>   | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> after deductible           | 60-visit limit per <u>plan</u> year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.   |
|  | <u>Rehabilitation services</u>  | \$50 <u>co-pay</u> per visit                  | 50% <u>coinsurance</u> after deductible           | <u>Preauthorization</u> required after 30 visits per <u>plan</u> year for each therapy: physical, occupational and speech. No coverage for services without <u>preauthorization</u> .   |
|  | <u>Habilitation services</u><br>(includes Applied Behavioral Analysis, for details please refer to member policy) | \$50 <u>co-pay</u> per visit                  | 50% <u>coinsurance</u> after deductible           | Cardiac and pulmonary rehab services from participating providers are 40% <u>coinsurance</u> and have a 36-visit maximum per <u>plan</u> year. <u>Preauthorization</u> required for all Applied Behavioral Analysis services.       |
|  | <u>Skilled nursing care</u>   | 40% <u>coinsurance</u> after deductible       | 50% <u>coinsurance</u> 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.               |

| Common Medical Event                                    | Services You May Need                     | Your Cost If You Use a Participating Provider    | Your Cost If You Use a Non-Participating Provider | Limitations, Exceptions, & Other Important Information   |
|---|---|--|---|--|
| If you need help recovering or have other special needs | <a href="#">Durable medical equipment</a> | 40% <a href="#">coinsurance</a> after deductible | Not covered                                       | Certain <a href="#">durable medical equipment</a> require <a href="#">preauthorization</a> . No coverage for services without <a href="#">preauthorization</a> .                         |
|   | <a href="#">Hospice service</a>           | 40% <a href="#">coinsurance</a> after deductible | 50% <a href="#">coinsurance</a> after deductible  | 185-day limit per <a href="#">plan</a> year  |
| If your child needs dental or eye care                  | 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 <a href="#">VSP.com</a> to find a participating vision provider |
|   | Glasses                                   | No charge  | Not covered                                       | Frames from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit <a href="#">VSP.com</a> to find a participating vision provider.                       |
|   | 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.   |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Does NOT Cover (This isn't a complete list. Check your policy or <a href="#">plan</a> document for other <a href="#">excluded services</a> .) |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>Abortion (except when the life of the mother is endangered)</li> </ul>  | <ul style="list-style-type: none"> <li>Hearing aids</li> </ul>          | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the United States</li> </ul> |
| <ul style="list-style-type: none"> <li>Acupuncture</li> </ul>  | <ul style="list-style-type: none"> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>                                    |
| <ul style="list-style-type: none"> <li>Cosmetic surgery</li> </ul>   | <ul style="list-style-type: none"> <li>Long-term care</li> </ul>        | <ul style="list-style-type: none"> <li>Weight loss program</li> </ul>   |
| <ul style="list-style-type: none"> <li>Dental care (Adult)</li> </ul>  |   |   |

| Other Covered Services (This isn't a complete list. Check your policy or <a href="#">plan</a> document for other covered services and your costs for these services.) |  |
|---|--|
| <ul style="list-style-type: none"> <li>Bariatric surgery if <a href="#">preauthorization</a> requirements are met</li> </ul>  | <ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul>   |
| <ul style="list-style-type: none"> <li>Chiropractic care if provided by a participating provider</li> </ul>   | <ul style="list-style-type: none"> <li>Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease</li> </ul> |

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**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](http://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](http://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](http://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](http://www.dol.gov/ebsa/healthreform) or the South Dakota Division of Insurance at 605-773-3563.

**Does this Coverage 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 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.

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 page.*—————

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 40%     |

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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$3,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$100          |
| <b>The total Peg would pay is</b> | <b>\$7,600</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 40%     |

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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$800          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,700</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 40%     |

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                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |