




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 1-800-322-2115 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network: \$1,500 Individual or \$3,000 Family. Out-of-Network: \$10,000 Individual or \$20,000 Family. Does not apply to pharmacy. <a href="#">Copays</a> do not count toward any <a href="#">deductibles</a> .	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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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 <a href="#">copayment</a> 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network: \$6,250 Individual / \$12,500 Family. Out-of-Network: \$20,000 Individual / \$40,000 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	No charge for the first 5 visits, then \$25 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 \$25 <a href="#">copay</a>
	<a href="#">Specialist</a> visit	\$75 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	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, ultrasound)	\$25 <a href="#">copay</a> per service	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Copay</a> applies when diagnostic test is performed in an office setting. <a href="#">Coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.averahealthplans.com](http://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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.averahealthplans.com/insurance/find-a-prescription-drug/">prescription drug coverage</a> is available at <a href="http://www.averahealthplans.com/insurance/find-a-prescription-drug/">www.averahealthplans.com/insurance/find-a-prescription-drug/</a>	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 <a href="#">preauthorization</a> . The <a href="#">preauthorization</a> for the drug must be approved before the drug will be covered.
	Tier 2: Generic medications	\$15 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 3: Preferred brand medications	\$50 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 4: Non-preferred brand medications	\$75 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 5: Specialty value medications	\$10 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 6: Specialty medications	30% <a href="#">coinsurance</a> after medical <a href="#">deductible</a> for 30-day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a>	\$500 <a href="#">copay</a>	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> for non-emergency transportation. No coverage for services without <a href="#">preauthorization</a> .
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for the first 5 visits, then \$25 <a href="#">copay</a> per therapy visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 \$25 <a href="#">copay</a> . Services other than therapy performed in the office or any service at a facility: 30% <a href="#">coinsurance</a> .  <a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
	Inpatient services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you are pregnant	Office visits	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply to certain preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	One visit equals a maximum of 4 hours, including private duty nursing.
	<a href="#">Rehabilitation services</a>	No charge for the first 5 visits, then \$25 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 \$25 <a href="#">copay</a> . Cardiac and pulmonary rehab services from participating providers are 30% <a href="#">coinsurance</a> and have a 36-visit maximum per <a href="#">plan</a> year.
	<a href="#">Habilitation services</a>	No charge for the first 5 visits, then \$25 <a href="#">copay</a> per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	

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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	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 services</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	185-day limit per <a href="#">plan</a> 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 <a href="#">VSP.com</a> 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 <a href="#">VSP.com</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Abortion (except when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the United States</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss program</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery if <a href="#">preauthorization</a> requirements are met</li><li>• Employee Assistance Program</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>

**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 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](#) \$1,500
- [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:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$3,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,960</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$1,500
- [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:

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

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$1,500
- [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:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</b>

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

