

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**  
**Avera Health Plans: Avera Ultra \$6000 Medical Deductible with \$0 Rx Deductible**

**Coverage Period:** Beginning on or after 01/01/2024  
**Coverage for:** Individual/Family  
**Plan Type:** PPO



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
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network \$6,000 Individual or \$12,000 Family. Out-of-Network \$15,000 Individual or \$30,000 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 \$9,450 Individual or \$18,900 Family. Out-of-Network \$30,000 Individual or \$60,000 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> .

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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="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	One <a href="#">copay</a> per office visit per day for services provided in the provider's office. The <a href="#">copay</a> is inclusive of all services done in an office setting except PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine, specialty medications and MRA.
	<a href="#">Specialist</a> visit	\$100 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	One <a href="#">copay</a> per in-network office visit per day for services provided in the provider's office. The <a href="#">copay</a> is inclusive of all services done in an office setting except PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine, specialty medications and MRA.
	Chiropractic visit	\$50 <a href="#">copay</a> per visit	Not covered	---none---
	<a href="#">Preventive care/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. Deductible and coinsurance apply for colonoscopy with non-participating provider.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Copay</a> is for minor lab and X-rays. Lab and X-ray performed in a hospital, surgical center or outpatient facility apply to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <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.

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>  More information about <a href="http://www.avera.org/marketplace/drug-formulary/">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	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: Generics 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	\$100 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 5: Specialty value medications	\$12 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 6: Specialty medications	30% <a href="#">coinsurance</a> for 30-day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---none---
	Physician/surgeon fees	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---none---
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	---none---
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <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>	\$50 <a href="#">copay</a> per visit	50% <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.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <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 fee	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	

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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 <a href="#">copay</a> per therapy visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Services other than therapy performed in the office or any service at a facility: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> .
	Inpatient services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
	Employee Assistance Program	No charge	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	\$50 <a href="#">copay</a> per visit	50% <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). One <a href="#">copay</a> per office visit per day for services provided in the provider's office. The <a href="#">copay</a> is inclusive of all services done in an office setting except PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine, specialty medications and MRA.
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60-visit limit per <a href="#">plan</a> year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Cardiac and pulmonary rehab services from participating providers are 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> and have a 36-visit maximum per <a href="#">plan</a> year.
	<a href="#">Habilitation services</a> (includes Applied Behavioral Analysis, for details please refer to member policy)	\$50 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</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 need help recovering or have other special needs	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <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>	40% <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 service</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <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	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	One frame 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> .)		
• Abortion (except when the life of the mother is endangered)	• Hearing aids	• Routine eye care (Adult)
• Acupuncture	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss program
• Dental care (Adult)	• Non-emergency care when traveling outside the United States	

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.)	
• Bariatric surgery if <a href="#">preauthorization</a> requirements are met	• Private-duty nursing
• Chiropractic care if provided by a participating provider	

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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 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](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

**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.

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

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## 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>	\$6,000
■ <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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$6,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,760</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>	\$6,000
■ <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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</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>	\$6,000
■ <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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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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>

