This is only a summary. If you want more details about coverage and costs, you can get the complete terms in the policy or plan document at www.AveraHealthPlans.com or by calling 1-888-322-2115.

Important Questions	Answers	Why this Matters
What is the overall deductible?	In-Network $6,550 Individual or $13,100 Family and Out-of-Network $5,000 Individual or $10,000 Family. Co-pays do not count toward any deductibles.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network $6,550 Individual or $13,100 Family and there is no maximum limit for Out-of-Network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.AveraHealthPlans.com or call 1(888) 322-2115.	If you use a participating provider, this plan will pay some or all of the costs of covered services. Be aware, your participating provider or facility may use a non-participating provider for some services. Plans use the term in-network, preferred or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

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 and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	40% coinsurance	---none---
	Specialist visit	0% coinsurance	40% coinsurance	---none---
	Other practitioner office visit	0% coinsurance for chiropractors	Not covered	Preauthorization is required after 20 chiropractic visits per calendar year. No coverage for services without preauthorization.
	Preventive care/screening/immunization	$0	Not covered	Age and frequency limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	Preauthorization required. No coverage for services without preauthorization. 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 and Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at AveraHealthPlans.com	Tier 1	0% coinsurance for 30-day supply	Not covered	Deductible must be met before copays apply for tiers 2 through 6. Some drugs require preauthorization. No coverage for drugs without preauthorization.
	Tier 2	0% coinsurance for 30-day supply	Not covered	
	Tier 3	0% coinsurance for 30-day supply	Not covered	
	Tier 4	0% coinsurance for 30-day supply	Not covered	
	Tier 5	0% coinsurance for 30-day supply	Not covered	
	Tier 6	0% coinsurance for 30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	0% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	---none---
	Emergency medical transportation	0% coinsurance	0% coinsurance	Preauthorization for non-emergency transportation.
	Urgent care	0% coinsurance	40% coinsurance	For out-of-network urgent care visits, you may contact the plan to determine if your visit qualifies for in-network benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fee	0% coinsurance	40% coinsurance	

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 and Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office - $0 co-pay per therapy visit	40% coinsurance	Services other than therapy performed in the office or any service at a facility: 0% coinsurance per visit
	Mental/Behavioral health inpatient services	0% coinsurance	40% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	Office - $0 co-pay per therapy visit	40% coinsurance	Services other than therapy performed in the office or any service at a facility: 0% coinsurance per visit
	Substance use disorder inpatient services	0% coinsurance	40% coinsurance	Preauthorization required
If you are pregnant	Prenatal and postnatal care	0% coinsurance	40% coinsurance	---none---
	Delivery and all inpatient services	0% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special needs	Home health care	0% coinsurance	40% coinsurance	60-visit limit per calendar year for services from non-participating providers. One visit equals a maximum of 4 hours, including private-duty nursing.
	Rehabilitation services	0% coinsurance	40% coinsurance	Preauthorization required after 30 visits per calendar year for each therapy: physical, occupational and speech. Cardiac rehab services from participating providers are 0% coinsurance. Cardiac rehab has a 36-visit maximum per calendar year.
	Habilitation services	0% coinsurance	40% coinsurance	
	Skilled nursing care	0% coinsurance	40% coinsurance	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 and Exceptions
If you need help recovering or have other special needs	Durable medical equipment	0% coinsurance	Not covered	Certain durable medical equipment require preauthorization.
	Hospice service	0% coinsurance	40% coinsurance	185-day limit per calendar year
If your child needs dental or eye care	Eye exam	$0	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.
	Glasses	$0	Not covered	Frames from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit VSP.com to find a participating vision provider.
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Weight loss program
- Non-emergency care when traveling outside the United States

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery if preauthorization requirements are met.
- Chiropractic care if provided by a participating provider.
- Private-duty nursing
- Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease.
- Medically-indicated termination of pregnancy when necessary to save the life of the mother

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-322-2115. You may also contact your state insurance department at (605) 773-3563.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Avera Health Plans at 1-888-322-2115, or the South Dakota Division of Insurance at 1-605-773-3563.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $990
- **Patient pays** $6,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,650
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$6,550**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $390
- **Patient pays** $5,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,010
Co-pays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses? ✘ No.

Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts.

Discrimination is Against the Law

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 Service Center at 1-888-322-4115, 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
3816 S. Elmwood, Suite 100, Sioux Falls, SD 57105-6538
1-800-322-2115 (phone), TTY 711, 1-800-269-8561 (fax)
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 by mail or phone at: US Department of Health and Human Services, 200 Independence Avenue SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in other Languages

For language assistance in your language call 1-888-322-2115.

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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).
- 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）
- ဟ်သူဉ်ဟ်သး:- နမ့ါကတိၤ ကညီ ကျိာ်အယိ, နမၤနဲ့ ကျိာ်အတၢ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လီၤ, ကိး 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).
- ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-322-2115 (टिटिवाइ: 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).
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113).
- MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-322-2115 (TTY: 1-800-877-1113).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 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.
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: 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).
- УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-322-2115 (телетайп: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS : 1-800-877-1113).