

IOWA – OCTOBER 2019
Benefit Chart of Medicare Supplement Insurance Plans
Standard Medicare Supplement Plans A, B, C, F, G and N
Medicare Select Supplement Plans A, B, C, F, G and N are available.

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Plans A, B, C, F, G and N are also available as Medicare Select Plans. Medicare Select plans contain restrictions on your use of specific hospitals and, in some cases, specific doctors or other healthcare providers to get full coverage. See Outline of Coverage sections for details about available plans.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2019 ²						\$5,560	\$2,780			

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

Service Area

Standard Plan Service Area: All counties in Iowa are included in the service area for the Standard Plan.

Select Plan Service Area: Dickinson, Emmet, Lyon, O'Brien, Osceola, Plymouth, Sioux and Woodbury Counties. (updated 11/27/2013)

Premium Information

Avera Health Plans can only raise your premium if we raise the premium for all policies like yours in this state. Your premiums are based on your attained age on the annual effective date of your policy.

Monthly Premium

ATTAINED AGE	Standard Plan A		Select Plan A		Standard Plan B		Select Plan B		Standard Plan C		Select Plan C	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
65	126.12	117.13	98.03	90.99	164.74	152.82	109.46	101.56	189.99	176.50	114.16	106.05
66	130.98	121.67	100.59	93.29	171.08	158.75	112.32	104.13	197.30	183.35	117.14	108.73
67	132.80	123.28	106.34	98.69	173.47	160.84	118.74	110.15	200.06	185.77	123.84	115.02
68	134.56	125.00	112.35	104.17	175.76	163.09	125.45	116.28	202.70	188.36	130.84	121.42
69	139.87	129.93	119.38	110.79	182.70	169.52	133.30	123.66	210.70	195.79	139.02	129.13
70	145.38	135.03	124.63	115.58	189.90	176.17	139.16	129.00	219.00	203.47	145.13	134.70
71	151.18	140.44	130.19	120.73	197.47	183.23	145.37	134.75	227.74	211.62	151.62	140.71
72	157.12	145.91	139.12	129.04	205.23	190.37	155.35	144.03	236.69	219.87	162.02	150.40
73	163.46	151.81	145.30	134.70	213.52	198.07	162.24	150.35	246.25	228.76	169.21	157.00
74	169.98	157.93	153.02	141.99	222.04	206.05	170.87	158.48	256.07	237.97	178.20	165.49
75	176.69	164.15	161.19	149.45	230.80	214.16	179.99	166.81	266.18	247.35	187.71	174.19
76	183.87	170.74	168.15	155.88	240.17	222.77	187.76	173.99	276.99	257.28	195.82	181.68
77	186.18	172.94	174.75	161.97	243.19	225.64	195.12	180.79	280.46	260.60	203.50	188.78
78	188.64	175.19	179.30	166.17	246.40	228.57	200.20	185.47	284.17	263.99	208.80	193.67
79	191.05	177.39	185.31	171.83	249.55	231.45	206.91	191.80	287.80	267.31	215.80	200.28
80+	208.79	193.97	195.61	181.44	272.73	253.07	218.42	202.52	314.53	292.28	227.79	211.47

Monthly Premium

ATTAINED AGE	Standard Plan F		Select Plan F		Standard Plan G		Select Plan G		Standard Plan N		Select Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	NA	NA	NA	NA	NA	NA	N/A	NA	NA	NA	N/A	NA
65	191.44	177.69	121.95	113.31	171.15	158.85	109.02	101.30	152.58	141.63	97.20	90.31
66	198.81	184.58	125.13	116.18	177.74	165.01	111.87	103.86	158.45	147.13	99.74	92.59
67	201.59	187.02	132.29	122.90	180.22	167.19	118.26	109.87	160.67	149.07	105.44	97.95
68	204.25	189.63	139.77	129.73	182.60	169.52	124.95	115.98	162.79	151.15	111.40	103.40
69	212.31	197.11	148.51	137.97	189.81	176.21	132.76	123.34	169.21	157.11	118.37	109.96
70	220.67	204.84	155.04	143.93	197.28	183.12	138.60	128.67	175.88	163.27	123.57	114.71
71	229.48	213.05	161.96	150.34	205.16	190.46	144.79	134.40	182.90	169.81	129.09	119.82
72	238.50	221.35	173.07	160.70	213.22	197.88	154.72	143.66	190.08	176.43	137.95	128.08
73	248.13	230.30	180.75	167.74	221.83	205.89	161.59	149.96	197.76	183.57	144.07	133.69
74	258.02	239.58	190.36	176.82	230.68	214.18	170.18	158.08	205.65	190.96	151.73	140.93
75	268.21	249.01	200.52	186.11	239.78	222.61	179.26	166.39	213.76	198.48	159.83	148.33
76	279.10	259.02	209.18	194.12	249.52	231.56	187.00	173.55	222.45	206.45	166.73	154.72
77	282.60	262.36	217.39	201.70	252.65	234.54	194.34	180.32	225.24	209.12	173.27	160.76
78	286.34	265.77	223.05	206.93	255.99	237.59	199.40	184.99	228.21	211.84	177.78	164.92
79	289.99	269.11	230.52	213.99	259.26	240.58	206.08	191.31	231.13	214.50	183.74	170.55
80+	316.93	294.25	243.34	225.95	283.34	263.06	217.54	202.00	252.60	234.54	193.95	180.09

DISCLOSURES

Use this Outline of Coverage to compare benefits and premiums among policies. This outline shows benefits of policies sold for effective dates on or after October 1, 2019. Policies sold for effective dates prior to October 1, 2019 may have different premiums. You do not need more than one Medicare Supplement Insurance Policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-approved hospital.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. We may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Avera Health Plans.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Service Center at Avera Health Plans, 3816 S. Elmwood Ave., Sioux Falls, SD 57105-6538 or your agent. If you send your policy back to us within 30 days after you receive it, we will treat your policy as if it had never been issued and return all of your payments.

REFUND OF PREMIUM

If termination is due to you ceasing to be eligible for this plan or we receive written notice that you wish to terminate your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to you.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Avera Health Plans nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

We offer Medicare Supplement plans, which do not restrict your use of hospitals. We have the right to purchase Standard Plan A, B, G and N at any time. Plans C and F are only available to Medicare Beneficiaries first eligible prior to 2020.

LIMITATIONS AND EXCLUSIONS

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicate payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicate payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

NETWORK HOSPITAL RESTRICTIONS

(Applies to Medicare Select Products Only)

Benefit Plans A, B, C, F, G and N are Medicare Select Supplement Insurance policies.

Services for outpatient surgery will be covered only if performed at an Avera owned or operated network hospital or outpatient surgery center which has a written agreement with Avera Health Plans to provide services.

Services for renal dialysis will be covered only if performed at a network hospital or dialysis center which has either a written agreement with Avera Health Plans or a written agreement with a network hospital to facilitate the network hospital's dialysis services.

Both inpatient and outpatient services provided and billed by any non-network hospital will NOT be covered except as described below.

Full benefits of your coverage will be paid if:

1. Services are provided in the following places: a physician's office, in another office setting (other than an outpatient surgery clinic); or at a skilled nursing facility.
2. The services are provided for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition and it is not reasonable to obtain such services through the network hospitals.
3. While traveling outside the service area, services will be covered from the first day you receive non-emergency services at a non-network hospital, up to 90 consecutive days, once per calendar year. Please refer to the Calendar Year Travel Benefit outlined in the next section. Travel must be for purposes other than the receipt of medical care.
4. Required services are not available at a network hospital in your service area and Avera Health Plans has approved the service by a non-network facility.

Other than hospital inpatient, hospital outpatient and facility services for outpatient surgery as noted above, you have no restrictions on benefits for services received in a non-hospital setting beyond standard limitations of this policy.

CALENDAR YEAR TRAVEL BENEFITS

You are entitled to a 90-consecutive-day travel benefit, once per calendar year. This travel benefit allows you to receive the full benefits of your coverage at a non-network hospital outside of the service area for non-emergency services. Your 90 days begins on the first day you receive non-emergency services from a non-network hospital. Travel must be for purposes other than to receive medical care.

NETWORK HOSPITALS

A network hospital is one that has a written agreement with Avera Health Plans Medicare Supplement product and has been designated by us to provide hospital services to our members under this policy. You may use any network hospital listed on your current Avera Health Plans Medicare Supplement Insurance Network Hospital Directory. This directory is updated periodically. To verify the status of a hospital, please call toll-free 1-888-322-2115 between 8 a.m. and 5 p.m. CT, Monday through Friday or contact us via our website at AveraHealthPlans.com and click Medicare Options.

NON-NETWORK HOSPITAL ADMISSION PROCEDURES

Prior to admission to a non-network hospital, you or your physician should call our Service Center at 1-888-322-2115 between 8 a.m. and 5 p.m. CT. We will confirm if the required services are available from a network hospital, and if not available, we will assist you in locating a hospital that provides the necessary service. **Calling Avera Health Plans Service Center prior to use of a non-network hospital eliminates the need for retrospective inquiry.**

These non-network hospital admission procedures do not apply in emergency situations or while you are traveling outside of the service area during your Calendar Year Travel Benefit period, as outlined above. Travel must be for purposes other than the receipt of medical care.

CONTINUATION OF COVERAGE

Any claim for continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditional upon your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare Select policies is discontinued for whatever reason or the service area no longer exists, your coverage can continue. Coverage will be continued under any other Medicare Supplement Insurance policy we have available continuing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY

You may request to convert this policy to a policy that does not contain a Network Hospital Restriction without submission of evidence of insurability at any time. Your request must be received by Avera Health Plans on or before the 20th day of the month, and will be effective the first day of the following month. The conversion will be to a Medicare Supplement Insurance policy with comparable or lesser benefits which is offered by us. Conversion is subject to the availability of an Avera Health Plans Medicare Supplement Insurance policy for sale in your state.

If you choose to convert back to a network hospital restricted plan, you will be subject to medical underwriting.

QUALITY ASSURANCE

When you purchase an Avera Health Plans Medicare Select Supplement Insurance plan, you agree to use a Network Hospital whenever possible. Our goal is to ensure access to high quality health care and we are continually striving to improve our services. To achieve this goal, our Quality Improvement Program allows us to monitor and evaluate the quality of care received by our insured. In addition, Avera Health Plans required the network hospitals to meet or exceed acceptable standards of quality care for their field and to maintain a quality assurance program that conforms with local and nationally recognized quality of care standards.

COMPLAINT AND APPEALS PHILOSOPHY - MEDICARE SELECT PRODUCTS ONLY

We seek to provide quality administration and services to insureds of our Medicare Supplement Insurance plans and network hospitals. There may be a time you are not fully satisfied with the administration, claims practices or services we provide or provided by a network hospital. It is the policy of Avera Health Plans to make reasonable efforts to resolve member and provider complaints. If you or your authorized representative is not satisfied, you have the right to file a complaint or grievance. You may submit a complaint or grievance within 180 days from the date you were notified of the action that is causing the complaint.

COMPLAINTS WHILE STAYING AT A NETWORK HOSPITAL

If, while staying at a network hospital, you have a complaint regarding the hospital's services, you may contact our Service Center by phone at 1-888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday to express the complaint. The complaint will be researched and you will receive a response within 30 days. Calls received by the Service Center between 5 p.m. and 8 a.m. CT, weekends and holidays, will be transferred to our after-hours answering service, where you may leave your name, policyholder identification number and phone number. Return calls will be placed the following business day.

OTHER COMPLAINTS

If you have questions or are dissatisfied with the quality care received from Avera Health Plans, care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, you may direct such inquires to the Avera Health Plans Service Center, 3816 S. Elmwood Ave., Sioux Falls SD 57105-6538, toll-free at 1-877-548-0834 without initiating a formal grievance. You will receive acknowledgement within three business days of receipt of the complaint. A written response will be sent to you within 30 business days of the complaint.

GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY

In the event you are dissatisfied with the response received to a complaint or with the disposition of a claim, you may submit a formal grievance by writing to the Avera Health Plans Complaint and Appeals Coordinator at 3816 S Elmwood Ave., Sioux Falls, SD 57105-6538.

Formal grievances in all other areas should be submitted to us in writing at the same address. A grievance must clearly state “this is a grievance”, or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.

Acknowledgement of receipt of the grievance will be mailed within three business days and the grievance will be investigated. A response will be sent within 30 days following the date the grievance is received and shall explain in detail the reasons for the determination.

If you are dissatisfied with an adverse outcome on a complaint or a grievance, you have the right to contact the Iowa Insurance Division at 601 Locust Street, 4th Floor, Des Moines, IA 50309. If you have questions or need additional assistance filing a complaint or grievance, you may contact the Office of Consumer Assistance for help at Iowa Consumer Advocate Bureau, 601 Locust Street, 4th Floor, Des Moines, IA 50309-3738, 1-877-955-1212.

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PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
<p>HOSPITALIZATION²</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p style="text-align: right;">First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days)</p> <p style="text-align: right;">Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days</p>	<p style="text-align: right;">All but \$1,364 All but \$341 per day All but \$682 per day</p> <p style="text-align: right;">\$0 \$0</p>	<p style="text-align: right;">\$0 \$341 per day \$682 per day</p> <p style="text-align: right;">100% Medicare Eligible Expense \$0</p>	<p style="text-align: right;">\$1,364 (Part A Deductible) \$0 \$0</p> <p style="text-align: right;">\$0³ All Costs</p>
<p>SKILLED NURSING FACILITY CARE²</p> <p>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.</p> <p style="text-align: right;">First 20 days 21st thru 100th day 101st day and after</p>	<p style="text-align: right;">All approved amounts All but \$170.50 per day \$0</p>	<p style="text-align: right;">\$0 \$0 \$0</p>	<p style="text-align: right;">\$0 Up to \$170.50 per day All Costs</p>
<p>BLOOD</p> <p style="text-align: right;">First 3 pints Additional amounts</p>	<p style="text-align: right;">\$0 100%</p>	<p style="text-align: right;">3 pints \$0</p>	<p style="text-align: right;">\$0 \$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p style="text-align: right;">All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p style="text-align: right;">Medicare copayment/coinsurance</p>	<p style="text-align: right;">\$0</p>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-Approved Amounts ²	\$0	\$0	\$185 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES			
Above Medicare-Approved Amounts	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-Approved Amounts ²	\$0	\$0	\$185 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICE			
Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment	\$0	\$0	\$185 (Part B Deductible)
First \$185 of Medicare-Approved Amounts ²			
Remainder of Medicare-Approved Amounts	80%	20%	\$0

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	<div style="text-align: right;"> All but \$1,364 All but \$341 per day All but \$682 per day </div> <div style="text-align: right;"> \$0 \$0 </div>	<div style="text-align: center;"> \$1,364 (Part A Deductible) \$341 per day \$682 per day </div> <div style="text-align: center;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div> <div style="text-align: right;"> \$0³ All Costs </div>
SKILLED NURSING FACILITY CARE² You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	<div style="text-align: right;"> All approved amounts All but \$170.50 per day \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div>	<div style="text-align: right;"> \$0 Up to \$170.50 per day All Costs </div>
BLOOD	<div style="text-align: right;"> First 3 pints Additional amounts </div>	<div style="text-align: right;"> \$0 100% </div>	<div style="text-align: right;"> 3 pints \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	<div style="text-align: center;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care </div>	<div style="text-align: center;"> Medicare copayment/coinsurance </div>	<div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$185 (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	 \$0	 \$0	 All costs
BLOOD First 3 pints Next \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$185 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	 100%	 \$0	 \$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies	 100%	 \$0	 \$0
Durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 80%	 \$0 20%	 \$185 (Part B Deductible) \$0

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	<div style="text-align: right;"> All but \$1,364 All but \$341 per day All but \$682 per day </div> <div style="text-align: right;"> \$0 \$0 </div>	<div style="text-align: right;"> \$1,364 (Part A Deductible) \$341 per day \$682 per day </div> <div style="text-align: right;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div> <div style="text-align: right;"> \$0³ All Costs </div>
SKILLED NURSING FACILITY CARE² You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	<div style="text-align: right;"> All approved amounts All but \$170.50 per day \$0 </div>	<div style="text-align: right;"> \$0 Up to \$170.50 per day \$0 </div>	<div style="text-align: right;"> \$0 \$0 All Costs </div>
BLOOD	<div style="text-align: right;"> First 3 pints Additional amounts </div>	<div style="text-align: right;"> \$0 100% </div>	<div style="text-align: right;"> 3 pints \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	<div style="text-align: right;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care </div>	<div style="text-align: right;"> Medicare copayment/coinsurance </div>	<div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$185 (Part B Deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	\$0	All costs
BLOOD First 3 pints Next \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$185 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$185 (Part B Deductible) 20%	\$0 \$0 \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	 <div style="text-align: right;"> All but \$1,364 All but \$341 per day All but \$682 per day \$0 \$0 </div>	 <div style="text-align: right;"> \$1,364 (Part A Deductible) \$341 per day \$682 per day 100% Medicare Eligible Expense \$0 </div>	 <div style="text-align: right;"> \$0 \$0 \$0 \$0³ All Costs </div>
SKILLED NURSING FACILITY CARE² You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	 <div style="text-align: right;"> All approved amounts All but \$170.50 per day \$0 </div>	 <div style="text-align: right;"> \$0 Up to \$170.50 per day \$0 </div>	 <div style="text-align: right;"> \$0 \$0 All Costs </div>
BLOOD	 <div style="text-align: right;"> \$0 100% </div>	 <div style="text-align: right;"> 3 pints \$0 </div>	 <div style="text-align: right;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	 <div style="text-align: right;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care </div>	 <div style="text-align: right;"> Medicare copayment/coinsurance </div>	 <div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$185 (Part B Deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	100% of Medicare Eligible Costs	\$0
BLOOD First 3 pints Next \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$185 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$185 (Part B Deductible) 20%	\$0 \$0 \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days	All but \$1,364 All but \$341 per day All but \$682 per day \$0 \$0	\$1,3464 (Part A Deductible) \$341 per day \$682 per day 100% Medicare Eligible Expense \$0	\$0 \$0 \$0 \$0 ³ All Costs
SKILLED NURSING FACILITY CARE² You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	All approved amounts All but \$170.50 per day \$0	\$0 Up to \$170.50 per day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$185 (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	 \$0	 100% Medicare Eligible Costs	 \$0
BLOOD First 3 pints Next \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$185 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	 100%	 \$0	 \$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$185 of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$185 (Part B Deductible) \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN N
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days	All but \$1,364 All but \$341 per day All but \$682 per day \$0 \$0	\$1,364 (Part A Deductible) \$341 per day \$682 per day 100% Medicare Eligible Expense \$0	\$0 \$0 \$0 \$0 ³ All Costs
SKILLED NURSING FACILITY CARE² You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	All approved amounts All but \$170.50 per day \$0	\$0 Up to \$170.50 per day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment <p style="text-align: right;">First \$185 of Medicare-Approved Amounts²</p> <p style="text-align: right;">Remainder of Medicare-Approved Amounts</p>	<p style="text-align: right;">\$0</p> <p style="text-align: center;">Generally 80%</p>	<p style="text-align: right;">\$0</p> <p style="text-align: center;">Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p style="text-align: right;">\$185 (Part B Deductible)</p> <p style="text-align: center;">Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	\$0	100% Medicare Eligible Costs
BLOOD <p style="text-align: right;">First 3 pints</p> <p style="text-align: right;">Next \$185 of Medicare-Approved Amounts²</p> <p style="text-align: right;">Remainder of Medicare-Approved Amounts</p>	<p style="text-align: right;">\$0</p> <p style="text-align: right;">\$0</p> <p style="text-align: right;">80%</p>	<p style="text-align: center;">All costs</p> <p style="text-align: right;">\$0</p> <p style="text-align: right;">20%</p>	<p style="text-align: right;">\$0</p> <p style="text-align: right;">\$185 (Part B Deductible)</p> <p style="text-align: right;">\$0</p>
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES <p style="text-align: right;">-Medically necessary skilled care services and medical supplies</p> <p style="text-align: right;">Durable medical equipment</p> <p style="text-align: right;">First \$185 of Medicare-Approved Amounts²</p> <p style="text-align: right;">Remainder of Medicare-Approved Amounts</p>	<p style="text-align: right;">100%</p> <p style="text-align: right;">\$0</p> <p style="text-align: center;">80%</p>	<p style="text-align: right;">\$0</p> <p style="text-align: right;">\$0</p> <p style="text-align: right;">20%</p>	<p style="text-align: right;">\$0</p> <p style="text-align: right;">\$185 (Part B Deductible)</p> <p style="text-align: right;">\$0</p>
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. <p style="text-align: right;">First \$250 each Calendar Year</p> <p style="text-align: right;">Remainder of Charges</p>	<p style="text-align: right;">\$0</p> <p style="text-align: right;">\$0</p>	<p style="text-align: right;">\$0</p> <p style="text-align: center;">80% to a lifetime maximum benefit of \$50,000</p>	<p style="text-align: right;">\$250</p> <p style="text-align: center;">20% and amounts over the \$50,000 lifetime maximum</p>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$185 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 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).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 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)。
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: (TTY: 1-800-877-1113).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).

- ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-322-2115 (TTY: 1-800-877-1113).
- တံသ့တံသး- နမူကတိ၊ ကညီ ကျိအသိ၊ နမူနာ ကျိအတိ၊ ဧကလော တလက်ဘူလ်စု၊ နိတံဘဲဘဲသ့န့လိ၊ ကိ: 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 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.
- ພາສາອັງກິດ: ພາສາອັງກິດ ສາມາດ ສະໜອງ ສຳລັບ ຜູ້ທີ່ ບໍ່ສາມາດ ສູນຍາມ ຫາກ ພາສາ ທ່ານ ບໍ່ເປັນ ພາສາ ອັງກິດ: ພາສາ ອັງກິດ ສາມາດ ສະໜອງ ສຳລັບ ຜູ້ທີ່ ບໍ່ສາມາດ ສູນຍາມ ຫາກ ພາສາ ທ່ານ ບໍ່ເປັນ ພາສາ ອັງກິດ: 1-888-322-2115 (ສຳລັບຜູ້ທີ່ບໍ່ສາມາດສູນຍາມ: TTY: 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)
- ບຽນຍັດ: ເປັນສິນສາມາດສືບພາຍ ສາສາໂຊຊ, ເສກຊ່ຽຍໃຊ້ກສາ ເຂາຍມິສກິດຊຽນ ສິນສາມາດສືບພາຍ ສາສາໂຊຊ ຈຽນ ຈຽນສັຕູ 1-888-322-2115 (TTY: 1-800-877-1113)។



Main Office Address:

3816 S. Elmwood Ave. Suite 100
Sioux Falls, SD 57105-6538

For other office locations, visit [AveraHealthPlans.com](https://www.averahhealthplans.com)

Toll-Free: 1-888-322-2115