Coverage Period: Beginning on or after 01/01/2018

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 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/ or call 1-888-322-2115 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	In-Network \$3,500 Individual or \$7,000 Family. Out-of-Network \$5,000 Individual or \$10,000 Family. Does not apply to pharmacy. Co-pays do not count toward any deductibles.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	In-Network \$7,200 Individual or \$14,400 Family and there is no out-of-pocket limit for out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket</u> <u>limit</u> ?	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 <u>out-of-pocket</u> <u>limit</u> .
Will you pay less if you use a network provider?	Yes. See <u>www.AveraHealthPlans.com</u> or call 1(888) 322-2115 for a list of network providers.	This plan uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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
	Primary care visit to treat an injury or illness	\$50 <u>co-pay</u> per visit	50% <u>coinsurance</u>	none
	Specialist visit	\$80 <u>co-pay</u> per visit	50% coinsurance	none
If you visit a health care provider's office	Chiropractic visit	\$50 <u>co-pay</u> per visit	Not covered	Preauthorization is required after 20 chiropractic visits per plan year. No coverage for services without preauthorization.
or clinic	Preventive care/screening/immunization	\$0	Not covered	Age and frequency limitations may apply. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	none
If you have a test	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Some imaging requires 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, Exceptions, & Other Important Information
	Tier 1: Preventive medications	\$0 <u>co-pay</u> for 30-day supply	Not covered	
If you need drugs to treat your illness or condition	Tier 2: Preferred Generics and some brand medications	\$10 <u>co-pay</u> for 30- day supply	Not covered	Certain drugs require
More information	Tier 3: Non-preferred generics and some brand medications	\$30 <u>co-pay</u> for 30- day supply	Not covered	preauthorization. The preauthorization for the drug must be
about <u>prescription</u> <u>drug coverage</u> is available at	Tier 4: Preferred brand medications	\$50 <u>co-pay</u> for 30- day supply	Not covered	approved before the drug will be covered. Tier 6 maximum out of pocket cost is \$250 per prescription.
www.avera.org/market place/drug-formulary/	Tier 5: Non-preferred brand medications	\$100 <u>co-pay</u> for 30- day supply	Not covered	
	Tier 6: Specialty medications, brand and generic	40% coinsurance	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	none
surgery	Physician/surgeon fees	40% coinsurance	50% coinsurance	none
	Emergency room care	40% coinsurance	40% coinsurance	none
If you need immediate medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	<u>Preauthorization</u> for non-emergency transportation. No coverage for services without <u>preauthorization</u> .
	Urgent care	\$50 <u>co-pay</u> per visit	50% coinsurance	For out-of-network <u>urgent care</u> visits, you may contact the <u>plan</u> to determine if your visit qualifies for innetwork benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Preauthorization required. No
	Physician/surgeon fee	40% coinsurance	50% coinsurance	coverage for services without preauthorization.

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	Outpatient services	Office: \$50 co-pay per therapy visit	50% coinsurance	Services other than therapy performed in the office or any service at a facility: 40% coinsurance.
health, or substance abuse needs	Inpatient services	40% coinsurance	50% coinsurance	<u>Preauthorization</u> required. No coverage for services without <u>preauthorization</u> .
	Office Visits	40% coinsurance	50% coinsurance	Cost sharing does not apply to certain
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	preventive services. Depending on the
If you are pregnant	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special needs	Home health care	40% coinsurance	50% coinsurance	60-visit limit per <u>plan</u> year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.
	Rehabilitation services	\$50 <u>co-pay</u> per visit	50% coinsurance	Preauthorization required after 30 visits per plan year for each therapy: physical, occupational and speech. No coverage for services without
	Habilitation services	\$50 <u>co-pay</u> per visit	50% coinsurance	preauthorization. Cardiac rehab services from participating providers are 40% <u>coinsurance</u> . Cardiac rehab has a 36-visit maximum per <u>plan</u> year.
	Skilled nursing care	40% coinsurance	50% 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, Exceptions, & Other Important Information
If you need help recovering or have	Durable medical equipment	40% coinsurance	Not covered	Certain <u>durable medical equipment</u> require <u>preauthorization</u> . No coverage for services without <u>preauthorization</u> .
other special needs	Hospice service	40% coinsurance	50% coinsurance	185-day limit per <u>plan</u> year
	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 <u>VSP.com</u> to find a participating vision provider
If your child needs dental or eye care	Glasses	\$0	Not covered	Frames from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit <u>VSP.com</u> to find a participating vision provider.
	Dental check-up	\$0	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 Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
Acupuncture	Hearing aids	Routine eye care (Adult)	
Cosmetic surgery	Infertility treatment	Weight loss program	
Dental care (Adult)	Long-term care	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 <u>preauthorization</u> requirements are met	Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease			
Chiropractic care if provided by a participating provider	Medically-indicated termination of pregnancy when necessary to save the life of the			
Cimopiactic care it provided by a participating provider	mother			
Private-duty nursing				

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the <u>plan</u> at 1-888-322-2115, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u> or the South Dakota Division of Insurance at 605-773-3563.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwiijigo holne' 1-888-322-2115.



About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	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)

In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$3,500	
Copayments	\$0	
Coinsurance	\$3,700	
What isn't covered		
Limits or exclusions	\$100	
The total Peg would pay is	\$7,300	

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-

controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,50
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

\$12,700

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,800
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$2,900

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost

Total Example 003t	Ψ1,700
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Total Example Cost

\$1 900

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 1-888-322-2115, 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 (1TY: 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: (ТТҮ: 1-800-877-1113).

لمحوظن: ذا اكن جد خحد ذاكر للاغنام فن مدخات اسملاعة دوغلاين بهورا ف لك اجلابن المحصل مقر ب 1-2115-872-888 مقر (ا محف مصلا لا وبكم: 1-1113-877-800(.

- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သ:- နမ့်ကတိုး ကညီ ကျိဉ်အယိ, နမာနှုံ ကျိဉ်အတာမာစားလာ တလက်ဘူဉ်လက်စာ နီတမီးဘဉ်သန္ဦလီး. ဂ 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.
- ጣስታወሻ: የሚናነሩት ቋንቋ ኣጣርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡
 ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 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)
- បុរយ័តុទ៖ បរើសេទិនជពអឲុនកនទិយាយ ភាសាខឲុមខែរ, បសវពាជនំនទួ យខាននកភាសា បោយមេទិនគតុលុន ឈួគីអាចមានសំរពារ់រំបារអ៊ើ នក។ ចទូរ ទទូរស័ពឲុន 1-888-322-2115 (TTY: 1-800-877-1113)។