Avera Health Plans: NESD Head Start SD599

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 07/01/2014
Coverage for: Individual/Family | Plan Type: PPO

This is only a summary. If you want more detail about your 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 $3,500 Individual $7,000 Family and Out-of-Network $5,000 Individual $10,000 Family. Does not apply to pharmacy and weight reduction surgery. 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?	**Yes.** $100 pharmacy deductible per member.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network $6,000 Individual $12,000 Family and Out-of-Network $10,000 Individual $20,000 Family.	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, weight reduction surgery 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**.

- **Copayments** 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**, **copayments** 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 & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Co-pay per visit	40% coinsurance	---none---
	Specialist visit	$70 Co-pay per visit	40% coinsurance	---none---
	Other practitioner office visit	$35 Co-pay per visit for chiropractors	Not covered	Precertification is required after 20 chiropractic visits per plan year. No coverage for services without precertification.
	Preventive care/screening/immunization	$0	Not covered	Age and frequency limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Precertification required. No coverage for services without precertification.

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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.AveraHealthPlans.com	Tier 1	$15 Co-pay for 30 day supply	Not covered	Some drugs require prior-authorization. No coverage for drugs without prior-authorization.
	Tier 2	$45 Co-pay for 30 day supply	Not covered	
	Tier 3	$75 Co-pay for 30 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	50% of covered services for weight reduction surgery.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	$200 Co-pay	$200 Co-pay	Co-pay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Precertification for non-emergency transportation.
	Urgent care	Same as if you visit a health care provider's office or clinic.	Same as if you visit a health care provider's office or clinic.	Same limitations apply for services received at provider's office or clinic. 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)	30% coinsurance	40% coinsurance	Precertification required. 50% of covered services for weight reduction surgery.
	Physician/surgeon fee	30% 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 & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 Co-pay per visit	40% coinsurance	---none---
	Mental/Behavioral health inpatient services	30% coinsurance	40% coinsurance	Precertification required.
	Substance use disorder outpatient services	$35 Co-pay per visit	40% coinsurance	---none---
	Substance use disorder inpatient services	30% coinsurance	40% coinsurance	Precertification required
If you are pregnant	Prenatal and postnatal care	30% coinsurance	40% coinsurance	---none---
	Delivery and all inpatient services	30% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	60-visit limit per plan year for services from non-participating providers. One visit equals a maximum of 4 hours.
	Rehabilitation services	$35 Co-pay per visit	40% coinsurance	Precertification required after 30 visits per plan year for each therapy: physical, occupational, habilitation and speech. Cardiac rehab services from participating providers are 30% coinsurance. Cardiac rehab has a 36-visit maximum per plan year.
	Habilitation services	$35 Co-pay per visit	40% coinsurance	
	Skilled nursing care	30% 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.
	Durable medical equipment	30% coinsurance	Not covered	Certain durable medical equipment require precertification.
	Hospice service	30% coinsurance	40% coinsurance	185-day limit per plan year
If your child needs dental or eye care	Eye exam	$0	Not covered	Routine exam during well child visit for children up to age 7.
	Glasses	Not covered	Not covered	---none---

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
	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
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss program

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 precertification requirements are met.
- Chiropractic care if provided by a participating provider.
- Non-emergency care when traveling outside the United States
- Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease.

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-322-2115. You may also contact your state insurance department, the 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.

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: 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 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** $2740
- **Patient pays** $4800

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	$3500
Co-pays	$20
Coinsurance	$1130
Limits or exclusions	$150
Total	**$4800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,864
- **Patient pays** $1,536

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	$410
Co-pays	$1,126
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,536**

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 preexisting 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**, **copayments**, 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 **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.