

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services**Avera Health Plans: Hand County**

Coverage Period: 09/01/2022 - 08/31/2023

Coverage for: Individual/Family

Plan Type: Non-Grandfathered PPO



The **Summary of Benefits and Coverage (SBC)** document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at [www.AveraHealthPlans.com](http://www.AveraHealthPlans.com) or call 1-888-322-2115. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-888-322-2115 to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	<b>In-Network \$1,000 Individual or \$2,000 Family.</b> Out-of-Network \$5,000 Individual or \$10,000 Family. Does not apply to pharmacy. Copays do not count toward any deductibles.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$50 pharmacy <u>deductible</u> per member.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	In-Network Individual \$3,500 or \$7,000 Family. Out-of-Network \$10,000 Individual or \$20,000 Family.	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance billed</u> charges and health care services this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.AveraHealthPlans.com">www.AveraHealthPlans.com</a> or call 1-888-322-2115 for a list of network providers.	This <u>plan</u> 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$35 <u>copay</u> per visit	40% <u>coinsurance</u> after <u>deductible</u>	---none---
	<u>Specialist</u> visit	\$70 <u>copay</u> per visit	40% <u>coinsurance</u> after <u>deductible</u>	---none---
	Chiropractic visit	\$35 <u>copay</u> per visit	Not covered	<u>Preauthorization</u> is required after 20 chiropractic visits per <u>plan</u> year. No coverage for services without <u>preauthorization</u> .
	<u>Preventive care/screening/immunization</u>	No charge	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$35 <u>copay</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Copay</u> is for minor lab and X-rays, waived if date of service is same as office visit. Lab and X-ray performed in a hospital, surgical center or outpatient facility apply to <u>deductible</u> and <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Some imaging requires <u>preauthorization</u> . Major lab and X-ray services may include PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine and MRA.



Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.avera.org/marketplace/drug-formulary/">www.avera.org/marketplace/drug-formulary/</a>	Tier 0: Preventive	No charge	Not covered	Prescription drugs are subject to a \$50 <u>deductible</u> per member per plan year. <u>Deductible</u> waived for generics. Certain drugs require <u>preauthorization</u> . The <u>preauthorization</u> for the drug must be approved before the drug will be covered.
	Tier 1: Generics and some brand medications	\$12 <u>copay</u> for 30-day supply	Not covered	
	Tier 2: Preferred brand medications	\$35 <u>copay</u> for 30-day supply	Not covered	
	Tier 3: Non-preferred brand medications	\$70 <u>copay</u> for 30-day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	---none---
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	---none---
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	---none---
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> for non-emergency transportation. No coverage for services without <u>preauthorization</u> .
	<u>Urgent care</u>	\$35 <u>copay</u> per visit	40% <u>coinsurance</u> after <u>deductible</u>	In-network benefit for services outside of service area. When using Out-of-Network Provider inside service area you may contact the plan to determine if your visit qualifies for in-network benefits.



Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	Preauthorization required. No coverage for services without <u>preauthorization</u> .
	Physician/surgeon fee	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	Office: \$35 <u>copay</u> per therapy visit	40% <u>coinsurance</u> after deductible	Services other than therapy performed in the office or any service at a facility: 40% <u>coinsurance</u> .
	Inpatient services	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	Preauthorization required. No coverage for services without <u>preauthorization</u> .
	Employee Assistance Program	No charge	Not covered	Limit of 5 visits per contract year for mental health and substance use disorder outpatient services combined. For a list of participating providers call 1-800-527-9394.
<b>If you are pregnant</b>	Office Visits	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
	Childbirth/delivery facility services	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
<b>If you need help recovering or have other special needs</b>	<u>Home health care</u>	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	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.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> per visit	40% <u>coinsurance</u> after deductible	Preauthorization required after 30 visits per <u>plan</u> year for each therapy: physical, occupational and speech. No coverage for services without <u>preauthorization</u> . Cardiac and pulmonary rehab services from participating providers are 40% <u>coinsurance</u> and have a 36-visit maximum per <u>plan</u> year.
	<u>Habilitation services</u>	\$35 <u>copay</u> per visit	40% <u>coinsurance</u> after deductible	



Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
<b>If you need help recovering or have other special needs</b>	<u>Skilled nursing care</u>	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	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.
	<u>Durable medical equipment</u>	40% <u>coinsurance</u> after deductible	Not covered	Certain <u>durable medical equipment</u> require <u>preauthorization</u> . No coverage for services without <u>preauthorization</u> .
	<u>Hospice service</u>	40% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	185-day limit per <u>plan</u> year
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Not covered	Routine eye exam for children up to age 7 during well child visit only.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

### Excluded Services & Other Covered Services:

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)</b>		
• Abortion (except when the life of the mother is endangered)	• Hearing aids	• Non-emergency care when traveling outside the United States
• Acupuncture	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss program
• Dental care (Adult)		

<b>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.)</b>	
• Bariatric surgery if <u>preauthorization</u> requirements are met	• Private-duty nursing
• Chiropractic care if provided by a participating provider	• Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease



**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

**Does this Coverage Provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this Coverage Meet the Minimum Value Standard? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-322-2115.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-322-2115.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-322-2115.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-322-2115.

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



About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$70
■ 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*)

**Total Example Cost \$12,700**

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$2,100

**What isn't covered**

Limits or exclusions	\$60
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**The total Peg would pay is \$3,560**

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost \$5,600**

**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$800
Copayments	\$1,100
Coinsurance	\$0

**What isn't covered**

Limits or exclusions	\$20
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**The total Joe would pay is \$1,920**

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$70
■ 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 \$2,800**

**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$400

**What isn't covered**

Limits or exclusions	\$0
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**The total Mia would pay is \$1,800**

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.



**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 Customer Care team at 1-888-322-2115, (TTY 711), 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

5300 S Broadband Ln  
Sioux Falls, SD 57108-2221

Fax 1-800-269-8561

Email [ComplaintAppeals@AveraHealthPlans.com](mailto: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 call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services  
200 Independence Avenue SW Room 509F, HHH Building  
Washington, D.C. 20201

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

## Getting Help in Other Languages

- **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).

- XIYYEEFFANNA: 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 (TTY: 1-800-877-1113).

- كنت إذا: ملحوظة لك توافر اللغوية المساعدة خدمات فإن اللغة، اذكر ت تحدث كنت إذا: ملحوظة  
برقم اتصل بالمجان لك توافر اللغوية المساعدة خدمات فإن اللغة، اذكر ت تحدث  
(1-800-877-1113): والى بك الم صم هتة فرقم (1-800-325-2115)

- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ອມໃຫ້ທ່ານ. ໂທ 1-888-322-2115 (TTY: 1-800-877-1113).

- ဟံသာဝတီ- နမူကတီး ကညီ ကျိတ်အသီး၊ နမူနာ ကျိတ်အတံးမၤစၢၤလၢ တလၢကညီလၢကတီး၊ နီတံးၤကညီသ့သ့လီၤ. ငါ်  
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.

- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚስትለው ቁጥር ይደውሉ 1-888-322-2115 (ሞሳምት ለተሳናቸው፡ 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).

- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សៅរ៍ជំនួយផ្នែកភាសា ដោយមិនគិតល្បួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).

2022 SG.LG.NPD-PD.ERCO.LCP.NGW-GW 3-4 SBC

AHP-DOC-001 (Form 0017-30) (08/20)