Coverage Period: Beginning on or before 01/01/2025 Coverage for: Individual/Family Plan Type: HMO

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 <u>deductible</u> ?	In-Network \$2,000 Individual or \$4,000 Family. Does not apply to pharmacy. <u>Copays</u> do not count toward any <u>deductibles</u> . No out- of-network coverage.	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> .
Are there services covered before you meet your <u>deductible</u> ?	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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
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 \$6,250 Individual or \$12,500 Family. No out-of-network coverage.	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 limit</u> ?	Premiums, balance billed charges, and health care services this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.AveraHealthPlans.com</u> 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</u> <u>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 <u>specialist</u> you choose without a <u>referral</u> .



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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	No charge for the first 5 visits, then \$25 <u>copay</u> per visit	Not covered	Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$25 <u>copay</u> .
<u>Specialist</u> visit	\$75 <u>copay</u> per visit	Not covered	none
Chiropractic visit	No charge for the first 5 visits, then \$25 <u>copay</u> per visit	Not covered	Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$25 <u>copay</u> .
Preventive care/screening/immunization	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.
Diagnostic test (x-ray, blood work)	\$25 <u>copay</u> per visit	Not covered	<u>Copay</u> is for minor lab and X-rays. 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)	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	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.
	Primary care       visit to treat an injury or illness         Specialist       visit         Chiropractic visit       Preventive care/screening/immunization         Diagnostic test (x-ray, blood work)       Diagnostic test (x-ray, blood work)	Services You May NeedParticipating ProviderPrimary care visit to treat an injury or illnessNo charge for the first 5 visits, then \$25 copay per visitSpecialist visit\$75 copay per visitChiropractic visitNo charge for the first 5 visits, then \$25 copay per visitPreventive care/screening/immunizationNo chargeDiagnostic test (x-ray, blood work)\$25 copay per visitImaging (CT/PET scaps MRIs)30% coinsurance after	Services You May NeedYour Cost H You Use a Participating ProviderNon-Participating ProviderPrimary care visit to treat an injury or illnessNo charge for the first 5 visits, then \$25 copay per visitNot coveredSpecialist visit\$75 copay per visitNot coveredChiropractic visitNo charge for the first 5 visits, then \$25 copay per visitNot coveredPreventive care/screening/immunizationNo chargeNot coveredDiagnostic test (x-ray, blood work)\$25 copay per visitNot covered30% coinsurance afterNot covered

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.avera.org/marketpla ce/drug-formulary/	Tier 1: Preventive medications	No charge for 30-day supply	Not covered		
	Tier 2: Generics medications	\$15 <u>copay</u> for 30-day supply	Not covered		
	Tier 3: Preferred brand medications	\$50 <u>copay</u> for 30-day supply	Not covered	Certain drugs require <u>preauthorization</u> . The <u>preauthorization</u> for the drug must	
	Tier 4: Non-preferred brand medications	\$75 <u>copay</u> for 30-day supply	Not covered	be approved before the drug will be covered.	
	Tier 5: Specialty value medications	\$10 <u>copay</u> for 30-day supply	Not covered		
	Tier 6: Specialty medications	30% <u>coinsurance</u> for 30-day supply	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	none	
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	none	
	Emergency room care	\$500 <u>copay</u>	\$500 <u>copay</u>	Copay waived if admitted.	
If you need immediate medical attention	Emergency medical transportation	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Preauthorization for non-emergency transportation. No coverage for services without preauthorization.	
	<u>Urgent care</u>	\$25 <u>copay</u> per visit	Not covered	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.	



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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
lf you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	Preauthorization required. No coverage
	Physician/surgeon fee	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	for services without preauthorization.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge for the first 5 visits, then \$25 <u>copay</u> per visit	Not covered	Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation or Rehabilitation. Not 5 visits per category. After 5 visits, subject to \$25 <u>copay</u> . Services other than therapy performed in the office or any service at a facility: 30% <u>coinsurance</u> after <u>deductible</u> .
	Inpatient services	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	Preauthorization required. No coverage for services without preauthorization.
	Employee Assistance Program	No charge	Not covered	Limit of 3 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.
lf you are pregnant	Office Visits	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	<u>Cost sharing</u> 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	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	



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 other special needs	Home health care	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	One visit equals a maximum of 4 hours, including private duty nursing.
	Rehabilitation services	No charge for the first 5 visits, then \$25 <u>copay</u> per visit	Not covered	Each member will receive first 5 office visits per year at no charge in the categories of Primary Care Physician, Chiropractic, Mental Health, Habilitation or Rehabilitation; excludes Applied Behavioral Analysis (ABA). Not 5 visits per category. After 5 visits, subject to \$25 <u>copay</u> . Cardiac and pulmonary rehab services from participating providers are 30% <u>coinsurance</u> after <u>deductible</u> and have a 36-visit maximum per <u>plan</u> year. Preauthorization required for all Applied Behavioral Analysis services.
	Habilitation services (includes Applied Behavioral Analysis, for details please refer to member policy)	No charge for the first 5 visits, then \$25 <u>copay</u> per visit	Not covered	
If you need help recovering or have other special needs	Skilled nursing care	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	100-day confinement limit for services from participating providers. Same confinement limit if readmitted with same diagnosis within 60 days.
	Durable medical equipment	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	Certain <u>durable medical equipment</u> require <u>preauthorization</u> . No coverage for services without <u>preauthorization</u> .
	Hospice service	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	185-day limit per <u>plan</u> year
If your child needs dental or eye care	Eye exam	No charge	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.
	Glasses	No charge	Not covered	One frame 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	No charge	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 <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u> .)					
<ul> <li>Abortion (except when the life of the mother is endangered)</li> </ul>	Hearing aids	Routine eye care (Adult)			
Acupuncture	Infertility treatment	Routine foot care			
Cosmetic surgery	Long-term care	Weight loss program			
Dental care (Adult)	<ul> <li>Non-emergency care when traveling outside the United States</li> </ul>				

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

Bariatric surgery if <u>preauthorization</u> requirements are met

Private-duty nursing

• Chiropractic care if provided by a participating provider

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 <a href="http://www.dol.gov/ebsa">www.dol.gov/ebsa</a>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="http://www.HealthCare.gov">Marketplace</a>. For more information about the <a href="http://www.HealthCare.gov">Marketplace</a>, visit <a href="http://www.HealthCare.gov">www.HealthCare.gov</a> 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.

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

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



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#### 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. **Mia's Simple Fracture** Peg is Having a Baby Managing Joe's type 2 Diabetes (9 months of in-network pre-natal care and a (a year of routine in-network care of a well-(in-network emergency room visit and follow up hospital delivery) controlled condition) care) The plan's overall deductible \$2,000 The plan's overall deductible \$2,000 The plan's overall deductible \$2,000 Specialist copayment Specialist copayment Specialist copayment \$75 \$75 \$75 30% Hospital (facility) coinsurance 30% Hospital (facility) coinsurance Hospital (facility) coinsurance 30% ■ Other coinsurance 30% ■ Other coinsurance 30% Other coinsurance 30% This EXAMPLE event includes services like: This EXAMPLE event includes services like: This EXAMPLE event includes services like: Specialist office visits (prenatal care) Primary care physician office visits (including Emergency room care (including medical supplies) Childbirth/Delivery Professional Services disease education) Diagnostic test (x-ray) Diagnostic tests (blood work) Durable medical equipment (crutches) Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Prescription drugs Rehabilitation services (physical therapy) Durable medical equipment (alucose meter) Specialist visit (anesthesia) \$5,600 **Total Example Cost** \$12,700 **Total Example Cost Total Example Cost** \$2,800 In this example, Peg would pay: In this example, Joe would pay: In this example, Mia would pay: Cost Sharing Cost Sharing Cost Sharing **Deductibles** \$2.000 Deductibles \$900 **Deductibles** \$1.300 \$10 \$1,100 \$1,100 Copayments Copayments Copayments Coinsurance \$3,200 \$0 Coinsurance Coinsurance \$0 What isn't covered What isn't covered What isn't covered Limits or exclusions \$0 Limits or exclusions \$60 \$20 Limits or exclusions \$5.270 \$2,020 \$2,400 The total Peg would pay is The total Joe would pay is The total Mia would pay is



#### 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

AveraHealthPlans.com

- 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 <u>ComplaintAppeals@AveraHealthPlans.com</u> 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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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 <u>http://www.hhs.gov/ocr/office/file/index.html</u>.

### **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).
- 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 (ТТҮ: 1-800-877-1113).
- ، ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة :إذا كنت تتحدث اذكر اللغة • فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-300-325-2115 )رقم هاتف الصم والبكم :1-300-

- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ບົວນູຽິບົວນ:- ຣຸຢຼາກອິເ ການີ້ ທີ່ຄິສພິ, ຣຸຍເຣຼົາ ທີ່ຄິສອາໂຍເອາເດາ ອາດາກິນູຽິດເກືອເ ຮືອອະເນາຊິວນຸຣູຽິດັນ. ດໍ
   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 있습니다1-888-322-2115 (TTY: 1-800-877-1113). 번으로 전화해 주십시오.
- ማስታወሻ: የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት 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, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).

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

