Coverage Period: Beginning on or after 01/01/2024

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 deductible?	In-network \$1,500 Individual or \$3,000 Family for Avera Preferred Providers and \$3,000 Individual or \$6,000 Family for Other Participating Providers. Copays do not count toward any deductibles. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 pharmacy <u>deductible</u> per member or \$100 pharmacy <u>deductible</u> per family.	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.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	In-network \$4,000 Individual or \$8,000 Family for Avera Preferred Providers and \$8,000 Individual or \$16,000 Family for Other Participating Providers. 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 plan 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 www.AveraHealthPlans.com 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.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



Avera Preferred Providers: Providers that work at Avera locations. Using a preferred provider will result in Tier 1 in-network benefits. **Other Participating Providers:** All other in-network providers. Using a participating provider will result in Tier 2 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
	Primary care visit to treat an injury or illness	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered	none
If you visit a health care	Specialist visit	Avera Preferred Providers: \$75 copay per visit Other Participating Providers: 50% coinsurance after deductible	Not covered	none
provider's office or clinic	Chiropractic visit	Avera Preferred Providers: No charge Other Participating Providers: No charge	Not covered	none
	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.
If you have a test	Diagnostic test (x-ray, blood work)	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered	Copay is for minor lab and X-rays. Lab and X-ray performed in a hospital, surgical center or outpatient facility apply to deductible and coinsurance.
ii you liave a test	Imaging (CT/PET scans, MRIs)	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	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	No charge for 30-day supply	Not covered	
If you need drugs to treat your illness or condition	Tier 2: Generics medications	\$25 <u>copay</u> for 30-day supply after <u>deductible</u>	Not covered	Prescription drugs are subject to a \$50 deductible per member and
More information about	Tier 3: Preferred brand medications	\$75 <u>copay</u> for 30-day supply after <u>deductible</u>	Not covered	\$100 deductible per family per calendar year for tiers 2 through 6. Certain drugs
prescription drug coverage is available at	Tier 4: Non-preferred brand medications	\$150 <u>copay</u> for 30-day supply after <u>deductible</u>	Not covered	require <u>preauthorization</u> . The preauthorization for the drug must be
www.avera.org/marketplac e/drug-formulary/	Tier 5: Specialty value medications	\$10 copay for 30-day supply after deductible	Not covered	approved before the drug will be covered.
<u></u>	Tier 6: Specialty medications	30% <u>coinsurance</u> for 30-day supply after <u>deductible</u>	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	none
Surgery Physician/surgeon fees Avera Preferred Production of the Participating Avera Preferred Production of the Participating Avera Preferred Production of the Participating Avera Preferred Production of the Preferred Produ	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	none	
	Emergency room care	40% coinsurance after deductible	40% coinsurance after deductible	none
If you need immediate	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	Preauthorization for non-emergency transportation. No coverage for services without preauthorization.
If you need immediate medical attention	<u>Urgent care</u>	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered C N	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.
If you have a hospital	Facility fee (e.g., hospital room)	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	Preauthorization required. No coverage
stay	Physician/surgeon fee	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	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	Outpatient services	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered	Services other than therapy performed in the office or any service at a facility: 40% coinsurance after deductible for Avera Preferred Providers and 50% coinsurance after deductible for Other Participating Providers.
health, behavioral health, or substance abuse needs	Inpatient services	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	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.
	Office Visits	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	Cost sharing does not apply to certain preventive
If you are pregnant	Childbirth/delivery professional services	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	(i.e. uiti asouriu).
	Home health care	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	One visit equals a maximum of 4 hours, including private duty nursing.
If you need help recovering or have other special needs	Rehabilitation services	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered	Cardiac and pulmonary rehab services from participating providers are 40% coinsurance after deductible for Avera Preferred Providers and 50% coinsurance after deductible for Other Participating
	Habilitation services (includes Applied Behavioral Analysis, for details please refer to member policy)	Avera Preferred Providers: No charge Other Participating Providers: 50% coinsurance after deductible	Not covered	Providers and have a 36-visit maximum per plan year. Preauthorization required for all Applied Behavioral Analysis services.



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
	Skilled nursing care	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	100-day confinement limit for services from participating providers. Same confinement limit if readmitted with same diagnosis within 60 days.
If you need help recovering or have other special needs	Durable medical equipment	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	Certain durable medical equipment require preauthorization. No coverage for services without preauthorization.
	Hospice service	Avera Preferred Providers: 40% coinsurance after deductible Other Participating Providers: 50% coinsurance after deductible	Not covered	185-day limit per <u>plan</u> year
	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 VSP.com to find a participating vision provider.
If your child needs dental or eye care	Glasses	No charge	Not covered	One frame from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit VSP.com 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 Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)				
 Abortion (except when the life of the mother is endangered) 	Hearing aids	Routine eye care (Adult)		
Acupuncture	Infertility treatment	Routine foot care		
Cosmetic surgery	Long-term care	Weight loss program		
Dental care (Adult)	 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	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 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 plan 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.



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>	\$1,50
■ Specialist copayment	\$75
■ 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:

\$1,500		
\$0		
\$2,500		
What isn't covered		
\$60		
\$4,060		

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

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	40%
■ Other <u>coinsurance</u>	40%

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example 303t \$\psi_0,000	Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$800	
Copayments	\$1,300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,120	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance Other coinsurance	40% 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:

Coot Sharing		
Cost Sharing		
<u>Deductibles</u>	\$1,500	
Copayments	\$200	
Coinsurance	\$200	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,900	

*Note: This plan has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> 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

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).
- * 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).

- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ທົ່ວລູໂທົ່ວລ:- နှစ့်ကတိုး ကညီ ကျိဉ်အယိ, နှမး၍ ကျိဉ်အတာမြာေားလ၊ တလက်ဘူဉ်လက်စုး နီတမီးဘဉ်သုန္နဉ်လီး. က်
 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 គឺអាចមានសំរាប់បំរើរអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).

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