



IMPORTANT: Electronic Disclosure Notice

This document is being furnished to you electronically at the request of the plan administrator, South Dakota Bankers Insurance & Services (“Plan Administrator”). Please review this document carefully and contact the Plan Administrator’s representative below with any questions. This document, along with the other important Plan information, is also available on the Plan’s website at <https://www.sdba.com/sdbbp-employees>.

To request and obtain a paper version of this document at no charge, please contact:

South Dakota Bankers Insurance & Services
PO Box 7086 | Yankton SD 57078
800-221-7551
health@sdba.com





Educate. Advocate. Grow.

Michael P. Feimer, President
South Dakota Bankers Insurance & Services Inc.
PO Box 1081
109 W. Missouri Ave.
Pierre, SD 57501

NOTICE

The South Dakota Bankers Benefit Plan (“Plan”) is a self-funded group health plan sponsored by the Trustees of the South Dakota Bankers Benefit Plan Trust (“Trust”). The Plan is comprised of various participating employer banks who are members of the South Dakota Bankers Association. The Plan constitutes both a bona fide association health plan and a single employer plan within the meaning of the ERISA Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan also constitutes a multiple employer welfare arrangement within the meaning of Section 3(40) of ERISA and a multiple employer trust within the meaning of Section 58-18-88 of the South Dakota Insurance Code.

Plan assets are held in trust pursuant to the terms of the Trust agreement. All benefit claims and allowable expenses of the Plan and Trust are paid from the Trust. The Trust constitutes a voluntary employees beneficiary association within the meaning of Internal Revenue Code section 501(c)(9) and is funded by both employer and employee contributions. South Dakota Bankers Insurance & Services, Inc. (“SDBIS”) is the plan administrator for purposes of ERISA. SDBIS receives a fee for its services directly from participating employer banks and receives no compensation or other fee from the Trust. Wellmark Blue Cross BlueShield (“Wellmark”) provides claims administration and provider network access services. Wellmark does not assume any financial risk or obligation for claim payment amounts.

The Following Supplemental Notice to Applies to Participating Employers Pursuant to South Dakota Administrative Rules 20:06:57:10, 11:

“This policy is issued by a multiple employer trust. Multiple employer trusts are not subject to all of the insurance laws and regulations of South Dakota. This policy is not covered by the South Dakota Life and Health Insurance Guaranty Association in the event of plan failure. Your participation in this plan makes you subject to assessments for health plan costs. By accepting coverage, you must participate in this plan for a minimum of three years to avoid penalties for early departure.”

“The benefits and coverages described herein are provided through a self-insured trust fund established and funded in full or in part by a group of employers. It is not a licensed insurance company.”





South Dakota Bankers Benefit Plan Trust Blue 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 www.wellmark.com or call 1-800-774-0384. 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 1-800-774-0384 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$500 person/ \$1,500 family per calendar year.	Generally, you must pay all 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. In- <u>network</u> <u>preventive care</u> , outpatient xray/lab and services subject to <u>copayments</u> are covered before you meet your <u>deductible</u> .	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$100 person/ \$200 family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific <u>deductibles</u> .	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-pocket limit</u> for this <u>plan</u>?	Health: \$1,500 person/ \$3,000 family per calendar year. Drug Card: \$1,500 person/ \$3,000 family per calendar year. The In- <u>Network</u> health and drug card <u>out-of-pocket</u> maximum amounts accumulate separately.	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, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.wellmark.com or call 1-800-774-0384 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider 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 <u>provider's</u> 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.

Important Questions	Answers	Why this Matters:
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> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	40% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	\$30 <u>copay</u> per <u>provider</u> per date of service	40% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	One preventive exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. Waive <u>coinsurance</u> for well-child care. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Lab: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in- <u>network</u> independent lab services for mental health/chemical dependency.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is at www.wellmark.com/prescriptions.</p>	Tier 1	\$10 <u>copay</u> per prescription	Not covered	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug.
	Tier 2	\$40 <u>copay</u> per prescription	Not covered	1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (retail and mail order).
	Tier 3	\$55 <u>copay</u> per prescription	Not covered	<u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy <u>Network</u> .
	Specialty drugs	\$85 <u>copay</u> per prescription	Not covered	<u>Specialty drugs</u> on the PrudentRx drug list (found at Wellmark.com) will have 30% <u>coinsurance</u> . If you enroll with PrudentRx, you will have \$0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> per date of service for facility and physician(s) services combined	\$250 <u>copay</u> per date of service for facility and physician(s) services combined	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$30 <u>copay</u> per provider per date of service for facility and physician(s) combined	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay</u> per provider per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$30 <u>copay</u> per <u>provider</u> per date of service applies to in-network home sleep studies.
	<u>Rehabilitation services</u>	Office: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	Office: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of 90 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	-----None-----
Children's dental check-up		Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care - Adult
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care (limited to 12 visits per calendar year)
- Most coverage provided outside the U.S.
- Private-duty nursing -
- short term intermittent home skilled 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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, you can contact: Wellmark at 1-800-774-0384 or Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan 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 plan meet the Minimum Value Standards? 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.

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

Wellmark Blue Cross and Blue Shield of South Dakota is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

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 <u>deductible</u>	\$500
■ PCP <u>copayment</u>	\$30
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$30
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>copayment</u>	\$30
■ Hospital(facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	20%

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	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

