

SOUTH DAKOTA

State Employee

Health Plan

: **\$750 Deductible Health Plan**

Coverage Period: 07/01/2016 - 06/30/2017

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

Coverage for: Employee and/or 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 <http://benefits.sd.gov> or by calling **1-605-773-3148**.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$750 Person / \$1,875 Family of three or more for network providers. \$1,500 Person / \$3,750 Family of three or more for out-of-network providers. Does not apply to preventive care or prescription drugs. Copays and coinsurance do not apply toward the deductible. Does not include the pharmacy deductible.	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 <u>deductibles</u> for specific services?	Yes. \$50 per person for prescription drug expenses. There are no other specific deductibles.	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 <u>out-of-pocket limit</u> on my expenses?	Yes. \$3,600 Person / \$8,125 Family of three or more for network providers. \$7,200 Person / \$16,250 Family of three or more for out-of-network providers. Pharmacy \$1,000 Person / \$2,500 Family of three or more.	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 <u>out-of-pocket limit</u> ?	Premiums and health care this plan doesn't cover. Additionally, for services from non-participating providers and pharmacies, balance-billed charges, and penalties for failure to obtain preauthorization.	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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of providers?	Yes. For a list of participating providers, see www.dakotacare.com or call 1-800-831-0785 .	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network 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 <u>specialist</u> ?	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 in Excluded Services section. See your policy or plan document for additional information about excluded services .

Questions: Call **1-605-773-3148** or visit us at <http://benefits.sd.gov>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-325-5598 to request a copy.



- **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**. Cannot change these example amounts this is federal language that must be copied.
- 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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	35% coinsurance	-----none-----
	Specialist visit	25% coinsurance	35% coinsurance	-----none-----
	Other practitioner office visit	25% coinsurance for chiropractor	35% coinsurance for chiropractor	Massage therapy is not covered.
	Preventive care/screening/immunization	No Charge	Not Covered	Deductible and coinsurance does not apply if you use a network provider.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	35% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://benefits.sd.gov	Generic drugs	\$10 copayment	\$10 copayment	Separate \$50/per person deductible applies each year. Covers up to 30-day supply retail or mail order. Certain medications require preauthorization.
	Brand Preferred drugs	\$40 copayment	\$40 copayment	
	Brand Non-preferred drugs	\$60 copayment	\$60 copayment	
	Specialty Preferred	\$60 copayment	\$60 copayment	
	Specialty Non-preferred	\$85 copayment	\$85 copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Physician/surgeon fees	25% coinsurance	35% coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$250 copayment per visit, plus 25% coinsurance	\$250 copayment per visit, plus 25% coinsurance	Copayment does not apply if admitted inpatient within 24 hours.
	Emergency medical transportation	25% coinsurance	25% coinsurance	-----none-----
	Urgent care	25% coinsurance	25% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Physician/surgeon fee	25% coinsurance	35% coinsurance	-----none-----

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Mental/Behavioral health inpatient services	25% coinsurance	35% coinsurance	
	Substance use disorder outpatient services	25% coinsurance	35% coinsurance	
	Substance use disorder inpatient services	25% coinsurance	35% coinsurance	
If you are pregnant	Prenatal and postnatal care	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Delivery and all inpatient services	25% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Rehabilitation services	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Habilitation services	Not Covered	Not Covered	Habilitation services are not covered.
	Skilled nursing care	25% coinsurance	35% coinsurance	Certain services may require preauthorization. Coverage is limited to 60 days/year.
	Durable medical equipment	25% coinsurance	35% coinsurance	Certain supplies may require preauthorization.
	Hospice service	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Routine eye exams are not covered.
	Glasses	Not Covered	Not Covered	Glasses are not covered.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered.

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.)

- Cosmetic Surgery (unless related to a mastectomy or an accident)
- Dental Care (Adult)
- Dental Check-Ups (Child)
- Eye Exams (Child)
- Glasses (Child)
- Habilitation Services
- Hearing Aids
- Long-Term Care
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine foot care
- Weight loss programs

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.)

- Acupuncture (when performed by MD/DC)
- Bariatric Surgery (when compliant with Weight Management Program)
- Chiropractic Care
- Infertility treatment (diagnosis and medically necessary treatment up to \$3,000 lifetime maximum for both medical and drug benefit)
- Private-Duty Nursing

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 1-800-325-5598. 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:

South Dakota State Employee Health Plan at 1-605-773-3148 or <http://benefits.sd.gov>

South Dakota Department of Revenue & Regulation, Division of Insurance at 1-605-773-3563 or insurance@state.sd.us

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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.**

Accessing Your Certificate of Coverage:

You can access your certificate of coverage at <http://benefits.sd.gov> choose the link for either Active Employee or Retiree/COBRA to be directed to the Forms & Documents menu, from there choose the Summary Plan Descriptions.

—————*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 \$5,030
- Patient pays \$2,510

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	\$800
Copays	\$80
Coinsurance	\$1,600
Limits or exclusions	\$30
Total	\$2,510

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

- Amount owed to providers: \$5,400
- Plan pays \$3,470
- Patient pays \$1,930

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	\$800
Copays	\$950
Coinsurance	\$100
Limits or exclusions	\$80
Total	\$1,930

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.

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