

# FY17 Health Plan Comparison

Below is a comparison chart to help you understand the differences, similarities and costs of the two Health Plans available to you and your family.

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY17				
Plan Details	\$750 Deductible Health Plan		\$1,800 Deductible Health Plan with HSA	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Eligible Preventive Services <sup>1</sup>	Covered at 100%	Not covered <sup>2</sup>	Covered at 100%	Not covered <sup>2</sup>
Plan Year Deductible	<ul style="list-style-type: none"> <li>•\$750 per person</li> <li>•\$1,875 per family of three or more</li> </ul>	<ul style="list-style-type: none"> <li>•\$1,500 per person</li> <li>•\$3,750 per family of three or more</li> </ul>	<ul style="list-style-type: none"> <li>•\$1,800 single coverage</li> <li>•\$3,600 family coverage</li> </ul>	<ul style="list-style-type: none"> <li>•\$3,600 single coverage</li> <li>•\$7,200 family coverage</li> </ul>
	If you have family coverage, the full family deductible must be met before benefits are paid for any family member.			
Copayment	•Emergency Room: \$250		N/A	
Coinsurance	<ul style="list-style-type: none"> <li>•Plan pays 75% after deductible</li> <li>•You pay 25%</li> </ul>	<ul style="list-style-type: none"> <li>•Plan pays 65% after deductible</li> <li>•You pay 35%</li> </ul>	<ul style="list-style-type: none"> <li>•Plan pays 75% after deductible</li> <li>•You pay 25%</li> </ul>	<ul style="list-style-type: none"> <li>•Plan pays 65% after deductible</li> <li>•You pay 35%</li> </ul>
Plan Year Out-of-Pocket Maximum (includes deductible)	<ul style="list-style-type: none"> <li>•\$3,600 per person</li> <li>•\$8,125 per family of three or more</li> </ul>	<ul style="list-style-type: none"> <li>•\$7,200 per person</li> <li>•\$16,250 per family of three or more</li> </ul>	<ul style="list-style-type: none"> <li>•\$3,600 single coverage or any one family member</li> <li>•\$8,125 family coverage per family of three or more</li> </ul>	<ul style="list-style-type: none"> <li>•\$7,200 single coverage or any one family member</li> <li>•\$16,250 family coverage per family of three or more</li> </ul>
<b>Prescription Drugs</b>				
Deductible	\$50 per person	\$50 per person	Included in Plan Deductible	
Pharmacy Out-of-Pocket Maximum	<ul style="list-style-type: none"> <li>•\$1,000 per person</li> <li>•\$2,500 per family of three or more</li> </ul>		Included in Plan Year Out-of-Pocket Maximum	

<sup>1</sup> To view eligible preventive care services, visit <http://benefits.sd.gov/preventivecare.aspx>.

<sup>2</sup>When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered by the plan if member visits a PHCS provider. If Member utilizes a non-PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the Member's responsibility to pay.

