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

Coverage Period: 07/01/2017 - 06/30/2018

South Dakota State Employee Health Plan : **$1800 Deductible Health Plan with HSA**

Coverage for: Employee and/or Family | **Plan Type:** High-Deductible

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, http://benefits.sd.gov. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-325-5598 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,800 /Individual or $3,600 /Family of two or more for network providers. $3,600 /Individual or $7,200 /Family of two or more for out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services and eligible preventive prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at http://benefits.sd.gov.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,100 /Individual or $8,625 /Family of three or more for network providers. $7,700 /Individual or $16,750 /Family of three or more for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover. Additionally, for services from out-of-network 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.
Will you pay less if you use a network provider?	Yes. See www.dakotacare.com or call 1-800-831-0785 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	35% coinsurance	None
	Specialist visit	25% coinsurance	35% coinsurance	None
	Chiropractic care	25% coinsurance	35% coinsurance	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. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://benefits.sd.gov	Generic drugs Preventive	25% coinsurance No Charge	25% coinsurance No Charge	Covers up to 90-day supply retail or mail order. Certain medications require preauthorization.
	Brand Preferred drugs Preventive up to 30 day supply 60-90 day supply	25% coinsurance $45 copayment $112.50 copayment	25% coinsurance $45 copayment $112.50 copayment	Covers up to 90-day supply retail or mail order. Certain medications require preauthorization.
	Brand Non-Preferred drugs Preventive up to 30 day supply 60-90 day supply	25% coinsurance $65 copayment $162.50 copayment	25% coinsurance $65 copayment $162.50 copayment	Covers up to 90-day supply retail or mail order. Certain medications require preauthorization.
	Specialty Preferred drugs Preventive up to 30 day supply	25% coinsurance $65 copayment	25% coinsurance $65 copayment	Covers up to 30 day supply through CVS Specialty. Certain medications require preauthorization.
	Specialty Non-Preferred drugs Preventive up to 30 day supply	25% coinsurance $90 copayment	25% coinsurance $90 copayment	Covers up to 30 day supply through CVS Specialty. Certain medications require preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	Certain procedures may require preauthorization.
	Physician/surgeon fees	25% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	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 fees	25% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Inpatient services	25% coinsurance	35% coinsurance	
If you are pregnant	Office visits	25% coinsurance	35% coinsurance	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	35% coinsurance	Certain services may require preauthorization.
	Childbirth/delivery facility services	25% coinsurance	35% coinsurance	Certain services may require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	35% coinsurance	Home health services 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	Skilled nursing services require preauthorization. Coverage is limited to 60 days/year.
	Durable medical equipment	25% coinsurance	35% coinsurance	Certain supplies may require preauthorization.
	Hospice services	25% coinsurance	35% coinsurance	Hospice services require preauthorization.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Routine eye exams are not covered.
	Children's glasses	Not Covered	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Not Covered	Dental check-ups are not covered.

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.)

- 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 (unless medically necessary)
- Weight Loss Programs

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

- 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: 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/healthreform, 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 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, contact:
South Dakota State Employee Health Plan at 1-605-773-3148 or http://benefits.sd.gov
South Dakota Department of Labor & Regulation, Division of Insurance at 1-605-773-3563 or http://dlr.sd.gov/insurance
Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 section.

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 deductible**	**$1,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$600
The total Peg would pay is	**$4,700**

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

■ **The plan's overall deductible**	**$1,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,260**

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

■ **The plan's overall deductible**	**$1,800**
■ **Specialist coinsurance**	**25%**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**25%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$25
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,825**

Note: These numbers assume the patient does not participate in the plan's condition management program. If you participate in the plan's condition management program, you may be able to reduce your costs. For more information about the condition management program, please contact: http://benefits.sd.gov.

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