

**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**

: **\$850 Deductible Health Plan**

**Coverage for:** Employee and/or Family

**Plan Type:** 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, <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](http://www.dol.gov/ebsa/healthreform) or [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-325-5598 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$850 /Individual or \$2,125 /Family of three or more for <u>network providers</u> . \$1,700 /Individual or \$4,250 /Family of three or more for <u>out-of-network providers</u> .	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care services</u> and <u>prescription drugs</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 preventive services at <a href="http://benefits.sd.gov">http://benefits.sd.gov</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$100 / person for <u>prescription drug</u> expenses. There are no other specific <u>deductibles</u> .	You must pay all the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	\$4,100 /Individual or \$8,625 /Family of three or more for <u>network providers</u> . \$7,700 /Individual or \$16,750 /Family of three or more for <u>out-of-network providers</u> . Pharmacy \$1,000 /Individual or \$2,500 /Family of three or more.	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> and health care this <u>plan</u> doesn't cover. Additionally, for services from <u>out-of-network providers</u> and pharmacies <u>balance-billed</u> charges, and penalties for failure to obtain <u>preauthorization</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.dakotacare.com">www.dakotacare.com</a> or call 1-800-831-0785 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 charge</u> 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.
<b>Do you need a referral to see a specialist?</b>	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		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% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	<u>Specialist</u> visit	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Chiropractic care	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Massage therapy is not covered.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	<u>Deductible</u> and <u>coinsurance</u> does not apply if you use a <u>network provider</u> . 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	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://benefits.sd.gov">http://benefits.sd.gov</a>	Generic drugs up to 30 day supply 60-90 day supply	\$15 <u>copayment</u> \$37.50 <u>copayment</u>	\$15 <u>copayment</u> \$37.50 <u>copayment</u>	Separate \$100/ person <u>deductible</u> applies each year. Covers up to 90-day supply retail or mail order. Certain medications require <u>preauthorization</u> .
	Brand Preferred drugs up to 30 day supply 60-90 day supply	\$45 <u>copayment</u> \$112.50 <u>copayment</u>	\$45 <u>copayment</u> \$112.50 <u>copayment</u>	Separate \$100/ person <u>deductible</u> applies each year. Covers up to 90-day supply retail or mail order. Certain medications require <u>preauthorization</u> .
	Brand Non-Preferred drugs up to 30 day supply 60-90 day supply	\$65 <u>copayment</u> \$162.50 <u>copayment</u>	\$65 <u>copayment</u> \$162.50 <u>copayment</u>	Separate \$100/ person <u>deductible</u> applies each year. Covers up to 90-day supply retail or mail order. Certain medications require <u>preauthorization</u> .
	Specialty Preferred drugs	\$65 <u>copayment</u>	\$65 <u>copayment</u>	Separate \$100/ person <u>deductible</u> applies each year. Covers up to 30 day supply through CVS Specialty. Certain medications require <u>preauthorization</u> .
	Specialty Non-Preferred drugs	\$90 <u>copayment</u>	\$90 <u>copayment</u>	Separate \$100/ person <u>deductible</u> applies each year. Covers up to 30 day supply through CVS Specialty. Certain medications require <u>preauthorization</u> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain procedures may require <u>preauthorization</u> .
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	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	<u>Emergency room care</u>	\$250 <u>copayment</u> /visit, plus 25% <u>coinsurance</u>	\$250 <u>copayment</u> /visit, plus 25% <u>coinsurance</u>	<u>Copayment</u> does not apply if admitted to inpatient within 24 hours.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Urgent care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .
	Inpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	

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 are pregnant	Office visits	25% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .
	Childbirth/delivery facility services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Home health</u> services require <u>preauthorization</u> .
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain services may require <u>preauthorization</u> .
	<u>Habilitation services</u>	Not Covered	Not Covered	<u>Habilitation services</u> are not covered.
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Skilled nursing</u> services require <u>preauthorization</u> . Coverage is limited to 60 days/year.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Certain supplies may require <u>preauthorization</u> .
	<u>Hospice services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Hospice services</u> require <u>preauthorization</u> .
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](http://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](http://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](http://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](http://www.dol.gov/ebsa/healthreform) and [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/](http://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)

■ <u>The plan's overall deductible</u>	\$850
■ <u>Specialist coinsurance</u>	25%
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	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	\$850
Copayments	\$40
Coinsurance	\$2,800
What isn't covered	
Limits or exclusions	\$600
<b>The total Peg would pay is</b>	<b>\$4,290</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$850
■ <u>Specialist coinsurance</u>	25%
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	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	\$950
Copayments	\$1,000
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,100</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$850
■ <u>Specialist coinsurance</u>	25%
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	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	\$850
Copayments	\$250
Coinsurance	\$150
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,250</b>

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.