



ANNUAL ENROLLMENT DATES: MAY 12-23, 2014

FY15 Decision Guide Retiree/COBRA

FY15 (July 1, 2014 - June 30, 2015)

**SOUTH DAKOTA
state employee
benefits program**
learn. act. thrive.

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Plan Changes for FY15

Health Plan

\$750 DEDUCTIBLE PLAN

- Increase \$500 Deductible Plan to \$750 Deductible Plan
- Increase Out-of-Pocket Maximums
- Add family Out-of-Pocket Maximum
- Add MRI/CT/PET scans to Tier 1 Services
- Expand preventive care services including contraceptives
- Increase pharmacy copayments
- Remove up to 90 day pharmacy refill copayment but you can still get up to 90 day supply

\$1,250 DEDUCTIBLE PLAN

- Increase \$1,000 Deductible Plan to \$1,250 Deductible Plan
- Increase Out-of-Pocket Maximums
- Add family Out-of-Pocket Maximum
- Add MRI/CT/PET scans to Tier 1 Services
- Expand preventive care services including contraceptives
- Increase pharmacy copayments
- Remove up to 90 day pharmacy refill copayment but you can still get up to 90 day supply

\$1,800 DEDUCTIBLE PLAN COMPATIBLE WITH HEALTH SAVINGS ACCOUNT (HSA)

- Increase Out-of-Pocket Maximums
- Add MRI/CT/PET scans to Tier 1 Services
- Expand preventive care services including contraceptives

Flexible Benefits

- Increase Dental premiums
- Changes to Dental benefits
- Changes to Vision premiums
- Changes to Vision benefits

What you need to know about the Health Plans

- If you do not enroll during Annual Enrollment, your coverage will remain the same.
- You must visit a DAKOTACARE network provider to receive the highest level of benefits.
- If you are having a Tier 1 service, you must visit a Tier 1 provider and facility to receive the highest level of benefits.
- In some cases, Health Management Partners must pre-authorize services or referrals. To view the Pre-authorization Listing visit <http://benefits.sd.gov>, choose Retiree/COBRA scroll over Forms/Documents and choose Forms/ Documents. The Pre-authorization Listing is in the Other section.
- Eligible preventive services are covered prior to satisfying your deductible. To view eligible preventive care services, visit <http://benefits.sd.gov/preventivecare.aspx>.
- Out-of-Network provider means:
 - A DAKOTACARE network provider did not provide care;
 - You did not receive approval from Health Management Partners for a referral to an out-of-network provider; or
 - You failed to obtain pre-authorization when necessary.
- The following charges do NOT apply to the out-of-pocket maximum:
 - Expenses not covered by the Plan.
- When insured under the \$1,800 Deductible Plan, all costs of prescription drugs apply to the deductible and then coinsurance. There are no prescription copayments.

Health Plan Options

\$750 Deductible Health Plan

- You must meet a \$750 per person or a \$1,875 family deductible (family of 3 or more).
- Copayment: Emergency Room \$250.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-of-pocket maximum has been met.
- A separate prescription drug deductible of \$50 per person applies before prescription drug coverage begins.

\$1,250 Deductible Health Plan

- You must meet a \$1,250 per person or a \$3,125 family deductible (family of 3 or more).
- Copayment: Emergency Room \$250.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-pocket-maximum has been met.
- A separate prescription drug deductible of \$50 per person applies before prescription drug coverage begins.

\$1,800 Deductible Health Plan with Health Savings Account (HSA)

- All eligible health plan expenses, including prescription drugs, apply toward meeting the deductible.
- There is a \$1,800 deductible for single coverage and a \$3,600 deductible for family coverage. The family deductible must be met by one or more individuals before any benefits will be paid.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-pocket-maximum has been met.
- Members pay for prescription drug expenses, which apply to the deductible until the deductible has been met. After the deductible has been met, the member pays 25% coinsurance after reimbursement by DAKOTACARE.

HSA MAXIMUM CONTRIBUTION FOR FY15

You can make tax-free contributions to your HSA, up to limits established by the IRS. The following are the maximum contributions you can make to your HSA in FY15 according to IRS regulations.

	HSA Contribution 2014*
Participant	\$3,300
Participant and spouse, children, or family	\$6,550

* Catch-up contributions are allowed for individuals age 55 or older and each individual age 55 or older can contribute an additional \$1,000 in FY15. Consult your financial planner or accountant for more information.

Health Plan Comparison

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

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY15						
Plan Details	\$750 Deductible Plan		\$1,250 Deductible Plan		\$1,800 Deductible Plan with HSA	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Eligible Preventive Services	Covered	65% covered	Covered	65% covered	Covered	65% covered
Plan Year Deductible	<ul style="list-style-type: none"> • \$750 per person • \$1,875 per family of three or more 	<ul style="list-style-type: none"> • \$1,500 per person • \$3,750 per family of three or more 	<ul style="list-style-type: none"> • \$1,250 per person • \$3,125 per family of three or more 	<ul style="list-style-type: none"> • \$2,500 per person • \$6,250 per family of three or more 	<ul style="list-style-type: none"> • \$1,800 single coverage • \$3,600 family coverage 	<ul style="list-style-type: none"> • \$3,600 single coverage • \$7,200 family coverage
					If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
Copayment	• Emergency Room: \$250		• Emergency Room: \$250		N/A	
Coinsurance	<ul style="list-style-type: none"> • Plan pays 75% after deductible • You pay 25% 	<ul style="list-style-type: none"> • Plan pays 65% after deductible • You pay 35% 	<ul style="list-style-type: none"> • Plan pays 75% after deductible • You pay 25% 	<ul style="list-style-type: none"> • Plan pays 65% after deductible • You pay 35% 	<ul style="list-style-type: none"> • Plan pays 75% after deductible • You pay 25% 	<ul style="list-style-type: none"> • Plan pays 65% after deductible • You pay 35%
Plan Year Out-of-Pocket Maximum	<ul style="list-style-type: none"> • \$3,250 per person • \$8,125 per family of three or more 	<ul style="list-style-type: none"> • \$6,500 per person • \$16,250 per family of three or more 	<ul style="list-style-type: none"> • \$4,250 per person • \$10,200 per family of three or more 	<ul style="list-style-type: none"> • \$8,500 per person • \$21,250 per family of three or more 	<ul style="list-style-type: none"> • \$4,350 single coverage • \$10,200 per family 	<ul style="list-style-type: none"> • \$8,700 single coverage • \$21,750 per family
Prescription Drugs						
Deductible	\$50 per person	\$50 per person	\$50 per person	\$50 per person	Included in Plan Deductible	
Pharmacy Out-of-Pocket Maximum	<ul style="list-style-type: none"> • \$1,000 per person • \$2,500 per family of three or more 		<ul style="list-style-type: none"> • \$1,000 per person • \$2,500 per family of three or more 		Included in Plan Year Out-of-Pocket Maximum	

Tier 1

How Tier 1 Works

- To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider.
- If you have a Tier 1 service at a Tier 1 facility by an approved Tier 1 provider, you will have a lower out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for services during a fiscal year.
- If you want to have a Tier 1 service at a Non-Tier 1 facility or by a Non-Tier 1 provider, you will pay a higher out-of-pocket maximum. Non-Tier 1 facilities and providers must be in the DAKOTACARE network.
- Tier 1 services require pre-authorization by Health Management Partners (HMP).
- Services you receive at the approved facility three days prior to a Tier 1 service and 30 days after the service (excludes bariatrics) are wrapped up into one bill for you. You will not receive multiple bills.
- Out-of-Network coinsurance of 35% and Out-of-Network Maximums apply if you do not utilize a DAKOTACARE provider.
- The complete list of Tier 1 services, facilities, providers and frequently asked questions is available at <http://benefits.sd.gov/tier1rc.aspx>.

COVERAGE FOR TIER 1					
\$750 Deductible Plan		\$1,250 Deductible Plan		\$1,800 Deductible Plan with HSA	
Tier 1*	Non-Tier 1	Tier 1*	Non-Tier 1	Tier 1*	Non-Tier 1
<ul style="list-style-type: none"> \$750 per person Deductible 25% Coinsurance \$3,250 Out-of-Pocket maximum \$8,125 Out-of-Pocket maximum per family 	<ul style="list-style-type: none"> \$750 per person Deductible 25% Coinsurance \$5,350 Out-of-Pocket maximum \$10,200 Out-of-Pocket maximum per family 	<ul style="list-style-type: none"> \$1,250 per person Deductible 25% Coinsurance \$4,250 Out-of-Pocket maximum \$10,200 Out-of-Pocket maximum per family 	<ul style="list-style-type: none"> \$1,250 per person Deductible 25% Coinsurance \$5,350 Out-of-Pocket maximum \$10,200 Out-of-Pocket maximum per family 	<ul style="list-style-type: none"> \$1,800 per person Deductible \$3,600 family Deductible 25% Coinsurance \$4,350 Out-of-Pocket maximum single \$10,200 Out-of-Pocket maximum per family 	<ul style="list-style-type: none"> \$1,800 per person Deductible \$3,600 family Deductible 25% Coinsurance \$5,350 Out-of-Pocket maximum single \$10,200 Out-of-Pocket maximum per family

*To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider.

TIER 1 FACILITIES, SERVICES AND PROVIDERS			
Sanford	Avera	Sioux Falls Specialty Hospital	Multiple Locations Statewide
<p><u>Cardiac</u></p> <p>Heart Bypass Surgery Cardiac Catheterization Balloon Angioplasty Pacemakers</p> <p><u>Orthopedic</u></p> <p>Back & Neck Surgery (including spinal fusion) Total Knee Replacement Total Hip Replacement</p> <p><u>Bariatric</u></p> <p>Weight Reduction Surgery Lap-band, Gastric Sleeve, and Roux-en-Y</p> <p>Must be enrolled and approved through the Bariatric Management program with Health Management Partners</p>	<p><u>Renal Care</u></p> <p>Kidney Transplants Dialysis</p>	<p><u>Gastroenterology</u></p> <p>Colonoscopies (does not apply to preventive colonoscopies) Upper GI and/or Endoscopies Hernia Repair Gallbladder</p>	<p><u>MRI/CT/PET Scans</u></p>
<ul style="list-style-type: none"> Must be a Sanford provider 	<ul style="list-style-type: none"> Must be an Avera provider 	<ul style="list-style-type: none"> Must be an approved provider 	<ul style="list-style-type: none"> Must be an approved provider

Prescription Drug Coverage

How Prescription Drug Coverage Works

- Under the \$750 Deductible and \$1,250 Deductible Plans there is a separate \$50 deductible (per person, per plan year) for prescription drugs. Copayments apply after the deductible is satisfied. If the price is less than the defined copayment, you will pay the lesser of the two amounts.
- There is no longer a up to 90 day copayment. You can fill prescriptions up to 90 day supply but you are responsible for three 30 day copayments.
- Under the \$1,800 Deductible Plan with HSA, a single \$1,800 deductible and \$3,600 family deductible apply to both medical expenses and prescription drug expenses combined. Prescription drug coinsurance applies toward the out-of-pocket maximum after reimbursement by DAKOTACARE.
- If a physician indicates Dispense as Written (DAW) or if the member requests the brand name product when a generic is available, the member will pay the applicable copayment or coinsurance PLUS the difference between the brand name medication and the contracted rate. This cost difference is referred to as an ancillary charge.

FY15 Prescription Drug Plan

- The formulary list is available at <http://benefits.sd.gov/Formsrc.aspx> under the pharmacy section.
- Brand Preferred medications are products that contain no generic equivalent, but are recognized by the Pharmacy and Therapeutics Committee to be preferred treatment options on the basis of clinical outcomes.
- Specialty Preferred medications are prescription medications that are typically developed on DNA-based technologies. These medications require specialized management, monitoring and/or delivery.
- A comprehensive list of specialty medications can be found at the following link: <http://cvscaremarksspecialtyrx.com/sites/default/files/pdf/SpecialtyDrugs.pdf>

PRESCRIPTION DRUG COVERAGE UNDER THE \$750 DEDUCTIBLE AND \$1,250 DEDUCTIBLE PLANS

Tier	up to 30 day supply
Tier 1 - Generic	\$10
Tier 2 - Brand Preferred	\$40
Tier 3 - Brand Non-Preferred	\$60
Tier 4 - Specialty Preferred	\$60
Tier 5 - Specialty Non-Preferred	\$85

Health Plan Contribution Rates

A health plan cannot be added if not currently in force. However, if coverage is currently in force, dependent(s) can be added to the plan.

Retiree Monthly Contribution Rates

MONTHLY CONTRIBUTION RATES (Effective 7/1/2014 through 12/31/2014)			
Coverage Level	\$750 Deductible Plan Contributions*	\$1,250 Deductible Plan Contributions*	\$1,800 Deductible Plan with HSA Contributions*
Retiree	\$729.94	\$574.88	\$379.34
Retiree + Child(ren)	\$887.55	\$698.83	\$436.03
Retiree + Spouse	\$1,440.42	\$1,024.10	\$717.18
Family	\$1,598.03	\$1,148.04	\$773.87
MONTHLY CONTRIBUTION RATES (Effective 1/1/2015 through 6/30/2015)			
Retiree	\$915.05	\$690.19	\$439.00
Retiree + Child(ren)	\$1,151.27	\$899.95	\$529.83
Retiree + Spouse	\$1,998.71	\$1,337.13	\$819.46
Family	\$2,234.93	\$1,546.89	\$910.28
* \$60 per person, per month will be added to your health plan contribution if you and/or your spouse use tobacco products.			

COBRA Monthly Contribution Rates

MONTHLY CONTRIBUTION RATES (Effective 7/1/2014 through 6/30/2015)			
Coverage Level	\$750 Deductible Plan Contributions*	\$1,250 Deductible Plan Contributions*	\$1,800 Deductible Plan with HSA Contributions*
Participation Only	\$531.79	\$513.71	\$498.59
Participant + Child(ren)	\$819.22	\$792.32	\$769.82
Participant + Spouse	\$1,148.26	\$1,109.01	\$1,076.16
Family	\$1,435.69	\$1,387.62	\$1,347.39
* \$60 per person, per month will be added to your health plan contribution if you and/or your spouse use tobacco products.			

Dental Plans

- The Dental Plans cannot be added if not currently in force. However, if coverage is currently in force, dependent(s) can be added to the plan.
- The South Dakota State Employee Benefits Program offers two Dental Plans provided by Ameritas.
- Under both the Base and the Enhanced Plans, you and/or your covered dependents can utilize any licensed dental provider.
- You can visit the provider of your choice and receive benefits but network providers agree to offer you a discount.

FY15 Dental Plan Comparison

Below is a comparison chart to help you understand the differences, similarities and costs of the two Dental Plans available to you and your family. For detailed information, see pages 9-13.

DENTAL PLAN COMPARISON CHART				
Plan Details	Base Plan		Enhanced Plan	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Deductible	\$25 per visit	\$25 per visit	\$25 per visit	\$25 per visit
Eligible Services	MCE (after deductible)	MCE (after deductible)	U&C (after deductible)	U&C (after deductible)
Plan Year Maximum Dental and Dental Fusion	<ul style="list-style-type: none"> • \$1,000 dental (per person) • vision benefits are based on schedule allowance per procedure, not to exceed \$1,000 dental maximum • see Base Plan 		<ul style="list-style-type: none"> • \$1,000 dental (per person) • vision benefits are based on schedule allowance per procedure, not to exceed \$1,000 dental maximum • see Enhanced Plan 	
Waiting Periods	<p>Members who did not enroll in either dental plan for FY14 or members who had a break in the State Ameritas coverage, will have a 1 year waiting period for Major and Orthodontic Services.</p> <p>Members can switch between dental plans during Annual Enrollment with no waiting periods.</p>		<p>Members who did not enroll in either dental plan for FY14 or members who had a break in the State Ameritas coverage, will have a 1 year waiting period for Major and Orthodontic Services.</p> <p>Members can switch between dental plans during Annual Enrollment with no waiting periods.</p>	
Orthodontics	\$1,000 lifetime benefit children only under age 19		\$1,500 lifetime benefit adults and children	
Dental Rewards**	No		Yes <ul style="list-style-type: none"> • Benefit Threshold \$500 • Annual Carryover Amount \$250 • Maximum Carryover \$1,000 	
<p>* Dental Rewards® apply to only the Enhanced Dental Plan.</p> <ul style="list-style-type: none"> • The Enhanced Dental Plan allows qualifying plan members to carryover part of the unused annual maximum. • Members must submit at least one claim for dental expenses incurred during the benefit year and stay at or under the threshold amount for benefits received for that year. The annual benefit threshold limit is \$500 (keep paid claims at or below this limit to earn Dental Rewards®). • Members may accumulate rewards up to the stated maximum carryover amount and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. • Dental Rewards® are available on the Enhanced Plan only, switching to the Base Plan will eliminate any roll over maximum previously established. 				

Base Dental Plan

- The Base Dental Plan is provided by Ameritas.
- There is a \$25 per visit deductible.
- This Base Dental Plan covers procedures based on the maximum covered expense (MCE). The MCE reimburses procedures based on a set dollar amount for each covered procedure code after the deductible.
- The member is responsible for the per visit deductible, charges that exceed the MCE allowance and any charges over the annual maximum.
- To view a complete list of MCE charges, visit www.ameritasgroup.com/stateSD and choose covered procedures.
- No more than the noted dental maximum can be applied to dental benefits, and no more than the noted vision maximum may be applied to vision benefits, with a ceiling of the FUSION® maximum for both.
- Dental Fusion is reimbursed for a set dollar amount based on frequency.
- You can visit the provider of your choice and receive benefits but network providers agree to offer you a discount. A complete list of network providers is available at www.ameritasgroup.com/stateSD.
- Questions? Call Ameritas at 800.487.5553 or visit www.ameritasgroup.com/stateSD.

Coverage Level	Monthly Premiums
Employee	\$27.91
Employee + 1 dependent	\$49.86
Employee + 2 dependents	\$72.30
Employee + 3 dependents or more	\$90.62

Maximum & Per Visit Deductible	Dental	Vision	FUSION®
annual maximum	\$1,000	see schedule	\$1,000
per visit deductible	\$25	\$0	\$25/visit dental

Dental Fusion Vision Schedule		Frequency
Exam	\$25.00	1 per plan year
Frame	\$40.00	1 per plan year
Lenses		
Single	\$35.00	1 per plan year
Bifocal	\$50.00	1 per plan year
Trifocal	\$65.00	1 per plan year
Lent	\$70.00	1 per plan year
Progressive	\$70.00	1 per plan year
Contacts	frames + lenses	1 per plan year

Dental Fusion benefit is only available when the dental maximum has not been reached. Vision discounts available at providers across the state. Visit www.ameritasgroup.com/stateSD to view a list of providers offering discounts. Benefit available for either glasses and frames, or contacts under each plan.



Enhanced Dental Plan

- The Enhanced Dental Plan is provided by Ameritas.
- There is a \$25 per visit deductible.
- The Enhanced Dental Plan covers procedures on a listed percentage based on the 75th percentile of usual and customary (U&C) charges and zip code of the dental provider.
- The member pays the per visit deductible, charges that exceed the 75th Percentile U&C, coinsurance, and charges that exceed the annual maximum.
- No more than the noted dental maximum can be applied to dental benefits, and no more than the noted vision maximum may be applied to vision benefits, with a ceiling of the FUSION® maximum for both.
- Dental Fusion is reimbursed for a set dollar amount based on frequency.
- You can visit the provider of your choice and receive benefits but network providers agree to offer you a discount. A complete list of network providers is available at www.ameritasgroup.com/stateSD.
- Questions? Call Ameritas at 800.487.5553 or visit www.ameritasgroup.com/stateSD.

Coverage Level	Monthly Premiums
Employee	\$47.45
Employee + 1 dependent	\$82.54
Employee + 2 dependents	\$109.59
Employee + 3 dependents or more	\$147.90

Maximum & Per Visit Deductible	Dental	Vision	FUSION®
annual maximum	\$1,000	see schedule	\$1,000
per visit deductible	\$25	\$0	\$25/visit dental

Dental Fusion Vision Schedule		Frequency
Exam	\$25.00	1 per plan year
Frame	\$40.00	1 per plan year
Lenses		
Single	\$35.00	1 per plan year
Bifocal	\$50.00	1 per plan year
Trifocal	\$65.00	1 per plan year
Lent	\$70.00	1 per plan year
Progressive	\$70.00	1 per plan year
Contacts	frames + lenses	1 per plan year

Dental Fusion benefit is only available when the dental maximum has not been reached. Vision discounts available at providers across the state. Visit www.ameritasgroup.com/stateSD to view a list of providers offering discounts. Benefit available for either glasses and frames, or contacts under each plan.



Photo courtesy of South Dakota Department of Tourism

Base Dental Plan

Preventive Services	Frequency	Coverage after Deductible
oral examinations	2 per plan year	MCE
bite-wing X-rays	2 per plan year	MCE
panoramic X-rays	1 in 3 years	MCE
prophylaxis	2 per plan year	MCE
fluoride treatments	1 per plan year age 18 and under	MCE
sealants	age 15 and under	MCE
Basic Services	Frequency	Coverage after Deductible
restorations amalgams /restorative composites	1 in 6 months per tooth	MCE
endodontics (anterior & posterior)	1 per tooth	MCE
denture repair	1 in 6 months per arch	MCE
simple extractions	as needed	MCE
anesthesia	in-conjunction with surgical service	MCE
Major Services	Frequency	Coverage after Deductible
crowns	1 per tooth new and replacement 1 in 5 years	MCE
fixed bridges (replacement 1 in 5 years)	new in-conjunction with covered extraction and replacement 1 in 5 years	MCE
dentures (full & partial replacement 1 in 5 years)	as needed	MCE
onlays	1 per tooth new and replacement 1 in 5 years	MCE
implants	1 per tooth	MCE
Orthodontic	Frequency	Coverage after Deductible
child only (under age 19)	lifetime max of \$1,000	50%

Enhanced Dental Plan

Preventive Services	Frequency	Coverage after Deductible
oral examinations	2 per plan year	100%
bite-wing X-rays	1 per plan year	100%
prophylaxis	2 per plan year	100%
fluoride treatments	1 per plan year age 18 and under	100%
Basic Services	Frequency	Coverage after Deductible
restorations amalgams/ restorative composites	1 in 6 months per tooth	80%
endodontics (anterior & posterior)	2 per plan year instead of prophylaxis	80%
denture repair	1 in 6 months	80%
simple extractions	as needed	80%
periapical X-rays	as needed	80%
sealants	age 15 and under	80%
space maintainers	as needed	80%
full mouth/panoramic X-rays	1 in 5 years	80%
Major Services	Frequency	Coverage after Deductible
crowns/crown implant/ repair	1 per tooth new and replacement 1 in 5 years	50%
fixed bridges (replacement 1 in 5 years)	new in-conjunction with covered extraction and replacement 1 in 5 years	50%
dentures (full & partial replacement 1 in 5 years)	as needed	50%
onlays	1 per tooth new and replacement 1 in 5 years	50%
implants	1 per tooth	50%
endodontics	1 per tooth	50%
periodontics	1 in 24 months for scaling and root planing; other services reviewed	50%
anesthesia	in-conjunction with surgical service	50%
Orthodontic	Frequency	Coverage after Deductible
adult and child	lifetime max of \$1,500	50%

Base Plan Example

AMERITAS DENTAL CLAIMS ILLUSTRATIONS FOR THE STATE OF SOUTH DAKOTA

The sample procedures listed below were taken from actual claims processed for State of South Dakota members enrolled under the Base Plan.**

**The plan pays the Maximum Covered Expense (MCE).
 Member responsibility: Network Provider: deductible + charges that Exceed MCE Allowance.
 Member responsibility: Out-of-Network: deductible + charges that Exceed MCE Allowance.
 When utilizing an Out-of-Network provider, there aren't any provider adjustments.

For questions regarding this illustration, call 800.487.5553.

Sample Dentist	Service Type	Code	Description	Submitted Charge	Provider Adjustment	Network Provider Accepted Fee	MCE Allowance	Exceeds MCE Allowance	Deductible Applied	Amount patient owes provider	Ameritas Covered Amount after Deductible
This claim illustration is based on the average charges received by Out-of-Network providers in the area for preventive services.											
Out-of-Network	Preventive	D0120	Exam	42.00	N/A	N/A	33.00	9.00	25.00	34.00	8.00
Out-of-Network	Preventive	D1110	Cleaning	76.00	N/A	N/A	70.00	6.00	0.00	6.00	70.00
			Total	118.00	N/A	N/A	103.00	15.00	25.00	40.00	78.00
This claim illustration is based on the average charges received by Network providers in the area for preventive visits.											
Network Dentist	Preventive	D0120	Exam	42.00	-8.00	34.00	33.00	1.00	25.00	26.00	8.00
Network Dentist	Preventive	D1110	Cleaning	76.00	-12.00	64.00	64.00	0.00	0.00	0.00	64.00
			Total	118.00	-20.00	98.00	97.00	1.00	25.00	26.00	72.00
This claim illustration is based on the average charges received by Out-of-Network providers in the area for restorative and major services.											
Out-of-Network	Basic	D2150	Amalgam Restoration	134.00	N/A	N/A	85.00	49.00	25.00	74.00	60.00
Out-of-Network	Major	D2740	Crown	872.00	N/A	N/A	357.00	515.00	0.00	515.00	357.00
			Total	1006.00	N/A	N/A	442.00	564.00	25.00	589.00	417.00
This claim illustration is based on the average charges received by Network providers in the area for restorative and major services.											
Network Dentist	Basic	D2150	Amalgam Restoration	134.00	-35.00	99.00	85.00	14.00	25.00	39.00	60.00
Network Dentist	Major	D2740	Crown	872.00	-158.00	714.00	357.00	357.00	0.00	357.00	357.00
			Total	1006.00	-193.00	813.00	442.00	371.00	25.00	396.00	417.00

Enhanced Plan Example

AMERITAS DENTAL CLAIMS ILLUSTRATIONS FOR THE STATE OF SOUTH DAKOTA

The sample procedures listed below were taken from actual claims processed for State of South Dakota members enrolled under the Enhanced Plan.**

**Procedures under the Enhanced Plan are subject to the 75th percentile U & C.
 Member responsibility: Network Provider: deductible + coinsurance.
 Member responsibility: Out-of-Network: deductible + charges that Exceed 75th Percentile + coinsurance.
 When utilizing an Out-of-Network provider, there aren't any provider adjustments.

For questions regarding this illustration, call 800.487.5553

Sample Dentist	Service Type	Code	Description	Submitted Charge	Provider Adjustment	Network Provider Accepted Fee	Exceeds 75th Percentile	Amount Covered by Plan	Deductible Applied	Amount Covered After Deductible	Patient's Plan Pays	Amount Payable by Plan	Amount patient owes provider
This claim illustration is based on the average charges received by Out-of-Network providers in the area for preventive services.													
Out-of-Network	Preventive	D0120	Exam	42.00	N/A	N/A	0.00	42.00	25.00	17.00	100%	17.00	25.00
Out-of-Network	Preventive	D1110	Cleaning	76.00	N/A	N/A	0.00	76.00	0.00	76.00	100%	76.00	0.00
			Total	118.00	N/A	N/A	0.00	118.00	25.00	93.00		93.00	25.00

This claim illustration is based on the average charges received by Network providers in the area for preventive visits.													
Network Provider	Preventive	D0120	Exam	42.00	-8.00	34.00	N/A	34.00	25.00	9.00	100%	9.00	25.00
Network Provider	Preventive	D1110	Cleaning	76.00	-12.00	64.00	N/A	64.00	0.00	64.00	100%	64.00	0.00
			Total	118.00	-20.00	98.00	0.00	98.00	25.00	73.00		73.00	25.00

This claim illustration is based on the average charges received by Out-of-Network providers in the area for restorative and major services.													
Out-of-Network	Basic	D2150	Amalgam Restoration	134.00	N/A	N/A	0.00	134.00	25.00	109.00	80%	87.20	46.80
Out-of-Network	Major	D2740	Crown	872.00	N/A	N/A	0.00	872.00	0.00	872.00	50%	436.00	436.00
			Total	1006.00	N/A	N/A	0.00	1006.00	25.00	981.00		523.20	482.80

This claim illustration is based on the average charges received by Network providers in the area for restorative and major services.													
Network Provider	Basic	D2150	Amalgam Restoration	134.00	-35.00	99.00	N/A	99.00	25.00	74.00	80%	59.20	39.80
Network Provider	Major	D2740	Crown	872.00	-158.00	714.00	N/A	714.00	0.00	714.00	50%	357.00	357.00
			Total	1006.00	-193.00	813.00	N/A	813.00	25.00	788.00		416.20	396.80

Vision Care Plan

- The Stand-Alone Vision Plan cannot be added if not currently in force. However, if coverage is currently in force, dependent(s) can be added to the plan.
- The Stand-Alone Vision Plan is provided by Ameritas.
- The Stand-Alone Vision Plan schedule is based on a set dollar amount and frequency.
- Examples of eligible expenses include eye exams, lenses, frames or contact lenses.
- This is a Stand-Alone Vision Plan and may be combined with the Dental Fusion that may include limited vision coverage.
- You can see the vision care doctor of your choice.
- Vision discounts available at providers across the state. Visit www.ameritasgroup.com/stateSD to view a list of providers offering discounts.
- Questions? Call Ameritas at 800.487.5553 or visit www.ameritasgroup.com/stateSD.

Coverage Level	Monthly Premiums
Employee	\$13.71
Employee + 1 dependent	\$24.19
Employee + 2 dependents	\$28.52
Employee + 3 dependents or more	\$35.99

Stand-Alone Vision Schedule		Frequency
Exam	\$45.00	1 per plan year
Frame	\$65.00	1 per plan year
Lenses		
Single	\$60.00	1 per plan year
Bifocal	\$80.00	1 per plan year
Trifocal	\$95.00	1 per plan year
Lent	\$100.00	1 per plan year
Progressive	\$100.00	1 per plan year
Contacts	frames + lenses	1 per plan year
Benefits increase when combined with the Dental Fusion, if applicable. Dental Fusion benefit is only available when you are enrolled in either the Base or Enhanced Dental Plan and the dental maximum has not been reached.		

Vision Care Plan Example

Stand-Alone Vision Schedule	Fee Submitted	Scheduled Benefit	Exceeds Scheduled Benefit	Amount Patient Owes Provider
Exam	\$75.00	\$45.00	\$30.00	\$30.00
Frame	\$61.00	\$65.00	\$0.00	\$0.00
Lenses				
Single	\$86.00	\$60.00	\$26.00	\$26.00
Bifocal	\$131.00	\$80.00	\$51.00	\$51.00
Trifocal	\$208.00	\$95.00	\$113.00	\$113.00
Lent	\$208.00	\$100.00	\$108.00	\$108.00
Progressive	\$208.00	\$100.00	\$108.00	\$108.00
Contacts	\$110.00	\$125.00	\$0.00	\$0.00
Benefits increase when combined with the Dental Fusion, if applicable. The contact allowance is equal to the frames+lenses, the lenses are based on a single vision unless otherwise noted on claims submittal.				

Enroll in Benefits: May 12-23, 2014

1. Review your Current Benefits Selections.

- Refer to your personalized confirmation statement(s) enclosed with this Decision Guide.

2. Read through this Decision Guide for What's New in FY15

- Review the enclosed Decision Guide.

3. Enroll for FY15 Benefits

To make changes, complete the enclosed form and return by May 23, 2014 to the Bureau of Human Resources Benefits Program.

IMPORTANT REMINDERS:

- Retiree/COBRA participants cannot enroll online.
- If you do not enroll/complete the enrollment form during FY15 annual enrollment, benefit selection(s) will remain the same as you currently have in FY14.

4. Life Insurance and Beneficiary Data

- Retiree and COBRA participants may continue Life coverage until the end of the month in which the participant reaches age 80.
- If you have questions about your Life Insurance, contact Risty Benefits at 877.573.7347, option 5 or 866.237.9411.

5. Second Enrollment in November 2014

- A second enrollment for Retirees only will be in November 2014 for coverage effective January 1, 2015. The second enrollment is for your health plan only.
- You will only be able to increase your state health plan deductible during the November enrollment. You may not move from a higher health plan deductible to a lower health plan deductible.
- More information will be mailed in November.
- Starting November 15, 2014, you will be able to buy health insurance through the Health Insurance Marketplace or your local insurance agent.
- While we are happy for you to remain on the state health plan if that is the best option for you and your family, we encourage you to compare the state rates and plan offerings to options available from the private market or the Health Insurance Marketplace.
- We believe that the state rates and health plan offerings are competitive with these alternative markets; however, each individual and family's circumstances determine specific rates and plans.
- You should take the time to determine which health plan is best for you. Specifically, families with incomes below 400% of the federal poverty rate are eligible for a subsidy through the Health Insurance Marketplace which may be financially advantageous as compared to state health plan retiree rates.
- To learn more about the Health Insurance Marketplace, visit www.healthcare.gov or visit with a trusted insurance agent.



Contacts and Resources

The South Dakota State Employee Health Plan works in partnership to provide high quality, competitively priced programs, and services. Below is a listing of our contacts and resources and the services they offer.

	CONTACT	ONLINE	PHONE/FAX
Benefits Program			
<ul style="list-style-type: none"> • Health Plan Questions • Enrollment Questions 	Bureau of Human Resources 500 East Capitol Pierre, SD 57501-5070	benefitswebsite@state.sd.us http://benefits.sd.gov	877.573.7347, option 2 605.773.3148 Fax: 605.773.6840
Latitude Wellness Programs			
<ul style="list-style-type: none"> • Health Assessment • Health Screenings • Latitude Wellness Program 	Health Management Partners 2301 West Russell Street Sioux Falls, SD 57105	latitude@state.sd.us http://benefits.sd.gov and choose Latitude Wellness Portal	877.573.7347, option 3 or 866.330.9886
DAKOTACARE			
<ul style="list-style-type: none"> • Coverage Questions • Provider Network • Claims Processing 	DAKOTACARE P.O. Box 7406 Sioux Falls, SD 57117-7406	www.DAKOTACARE.com DAKOTACARE Flex Online www.dakotacareflexonline.com DAKOTACARE Access http://secure.healthx.com/stsd.asp	877.573.7347, option 1 or 800.831.0785 Fax: 605.336.0270 (Attn: Claims)
Health Management Partners			
<ul style="list-style-type: none"> • Case Management • Condition Management • Medical Pre-authorizations • Medical Management • Our Healthy Baby 	Health Management Partners 2301 West Russell Street Sioux Falls, SD 57105	www.hmpsd.com	877.573.7347, option 3 or 866.330.9886 Fax: 605.731.1905
Ameritas			
<ul style="list-style-type: none"> • Dental • Vision 	Ameritas Group Claims PO Box 82520 Lincoln, NE 68501	group@ameritas.com www.ameritasgroup.com/stateSD	877.573.7347, option 5 or 800.487.5553 Fax: 402.467.7336
Risty Benefits, Inc.			
<ul style="list-style-type: none"> • Life and AD&D 	Risty Benefits, Inc. 1324 S. Minnesota Sioux Falls, SD 57105	help@ristybenefits.com www.southdakotaflexbenefits.com	877.573.7347, option 4 or 866.237.9411

Update Your Email Address

The South Dakota State Employee Benefits Program sends communication electronically. Send your email address to retireecobra@state.sd.us.