

## **MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN**

The Plan Year begins on July 1<sup>st</sup> and ends on June 30<sup>th</sup> of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail with in this document.

### ***PLAN YEAR DEDUCTIBLE***

Members in the \$1,800 Deductible Plan must satisfy a \$1,800 Single Deductible or a \$3,600 Family Deductible each Plan Year. All eligible charges, including prescription drugs, apply to Deductible. If member has family coverage (two or more covered members) the Family Deductible must be met before payment of benefits will begin.

The Family Deductible applies to families with two or more covered family members enrolled in the same Plan.

The Plan will begin paying benefits as soon as the Deductible is met. The Family Deductible is satisfied when at least one or a combination of family member has medical and pharmacy expenses that total the Family Deductible amount. One family member can meet the entire Family Deductible.

Only charges which apply to the Single Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible.

### ***HOW THE DEDUCTIBLE IS SATISFIED***

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year. Single Coverage - \$1,800 Deductible, Family Coverage - \$3,600.

The Deductible applies separately to each Member, except:

- (a) One Member can meet the Family Deductible of \$3,600 when enrolled in the \$1,800 Deductible Plan with Spouse or Dependent coverage.

Only charges which apply to the Single Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the Single Deductible (\$1,800) or Family Deductible (\$3,600) is met.

- (b) If maternity charges are incurred for a mother and newborn child during the birth of the child, one Deductible applies to the eligible charges for both individuals — if they are discharged from the Hospital at the same time.

In the event of a birth by a dependent mother, one Deductible and Coinsurance applies to the eligible charge for the dependent mother. The charges in connection with a newborn of a dependent mother are not covered.

Non-covered charges do not apply to the Deductible. This includes charges above the Usual, Customary, and Reasonable (UCR) charges or the Plan Maximum Allowable Charges (MAC). The cost difference when a member chooses a provider, service or supply that is not an approved provider, service or supply by the plan does not apply to the deductible.

## ***COMBINED FAMILY DEDUCTIBLE***

With IRS rules, there is no opportunity for combined Deductibles under the \$1,800 Deductible Plan.

## ***HEALTH SAVINGS ACCOUNT (HSA)***

A Health Savings Account (HSA) is an account which enables the member to pay for covered medical expenses with pre-tax dollars.

Members enrolled in the \$1,800 Deductible Plan are eligible to establish a Health Savings Account.

Medical expenses, which are eligible for reimbursement, are described under the Internal Revenue Code, Section 152. See IRS Publication 502 for a complete list, or consult with a qualified tax consultant. [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf).

Contributions the member and the State make grow with interest over time and can be taken with the member when the member retires or terminates employment with the State. Contributions, earnings, and withdrawals, used for qualifying medical care are all tax-free.

If a member establishes an HSA, the state will contribute \$300 to the account. The member can also make tax-free contributions to the HSA, up to limits established by the IRS.

Catch-up contributions in the amount of \$1,000 are allowed for individuals age 55 or older. Unused Health Savings Account contributions may be carried over from one Plan Year to the next.

	Employer		Employee	HSA Contribution 2014
Employee Only	\$300	+	\$3,000	\$3,300
Employee and Spouse	\$300	+	\$6,250	\$6,550
Employee and child(ren)	\$300	+	\$6,250	\$6,550
Family	\$300	+	\$6,250	\$6,550

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### COINSURANCE UNDER THE \$1,800 DEDUCTIBLE PLAN

Once the Deductible is satisfied, the Member pays a percentage of the allowable costs (the “Coinsurance” or “Benefit Percentage”).

The type of service received and the provider used determines the benefits covered by the Plan and whether Copayments or Coinsurance are payable. If care is managed by the Physician and coordinated through the DAKOTACARE network of providers, Coinsurance is 25%, when applicable. If care is provided out-of-network, the Member must meet a \$3,600 Deductible and Coinsurance increases to 35% for most covered expenses. The Member also pays any charges above Usual, Customary, and Reasonable (UCR) or Maximum Allowable Charges (MAC).

With IRS rules, there are no copayments under the \$1,800 Deductible Plan.

**NOTE:** If a Plan Member is Hospitalized over two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year’s Out-of-Pocket Maximum. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

<b>Eligible Members</b>	All benefit-eligible Members.	Member Responsibility*
<b><i>Deductible</i></b>		\$1,800 Single Coverage
<b><i>In-Network</i></b>		\$3,600 Family Deductible must be met before benefits are paid for any family member.
<b><i>Out-of-Network</i></b>		\$3,600 Single Coverage \$7,200 Family Deductible must be met before benefits are paid for any family member
<b><i>Coverage In-Network</i></b>	(a) Emergency Room Visit	Applies to Deductible Coverage
	(b) Prescription Drugs	Applies to Deductible then Coinsurance

\* See Covered Charges, for additional information.  
Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum.

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Eligible Members	All benefit-eligible Members.	Member Responsibility**
<b>Room and Board Coverage</b>	(a) Private Room*	When Medically Necessary, the daily charge made by the facility for: <ul style="list-style-type: none"> <li>• semi-private accommodations;</li> <li>• private accommodations</li> </ul>
	(b) Other Accommodations*	Full Semi-Private Room Charge
<b>Benefit Maximums (lifetime maximum per person)</b>	(a) Organ Procurement for Transplant*	\$50,000
	(b) Diagnosis and Treatment:	
	7) Temporomandibular Joint Syndrome (TMJ)*	\$5,000
	8) Gastric Bypass Surgery and Similar Types of Surgery*	1 per person
	9) Ossonon Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis)	\$5,000
(c) Infertility Diagnosis and Medically Necessary Treatment	\$3,000 for all medical services combined <i>(Excludes infertility drugs)</i>	
(d) Smoking Cessation Aids that Require a Prescription	180 days	

\* *These services must be pre-authorized and performed at a preferred contracted facility.*

\*\* *See Covered Charges, for additional information.*

*Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum.*

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### ***BENEFIT PERCENTAGES (COINSURANCE) UNDER THE \$1,800 DEDUCTIBLE PLAN***

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE Primary Care Provider to manage and coordinate care for themselves, a Spouse, and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If members use a DAKOTACARE Network provider, the member is responsible for the Deductible, then 25% Coinsurance. If members use a non-DAKOTACARE Network provider, the member is responsible for the Out-of-Network Deductible, then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE specialists or Hospitals as necessary. In some cases, a DAKOTACARE specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the Chiropractic Associates LTD of South Dakota (CASD) Chiropractic Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-CASD chiropractors are used, the Member is responsible for Out-of-Network Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton is used, the Member is responsible for Deductible, then 25% Coinsurance.

### ***MEDICAL AND PHARMACY OUT-OF-POCKET MAXIMUM UNDER THE \$1,800 DEDUCTIBLE PLAN***

The medical and pharmacy Out-of-Pocket Maximum is \$4,350 for Single coverage and \$10,200 for Family coverage each Plan Year. The maximum consists of any Deductible and Coinsurance payments. One family member could satisfy the Family annual Out-of-Pocket Maximum.

If a Tier 1 service is done at a Tier 1 facility, the Out-of-Pocket Maximum remains at \$4,350 per person or \$10,200 per family of three or more, for medical and pharmacy costs. If a Tier 1 service available at a Tier 1 facility is done at a Non-Tier 1 facility but still in-network, the medical Out-of-Pocket Maximum for medical and pharmacy is \$5,350 per person or \$10,200 per family of three or more.

When a Member receives services from DAKOTACARE and non-DAKOTACARE providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$8,700 for Single coverage and \$21,750 for Family coverage.

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In-Network	
<ul style="list-style-type: none"> <li>• Deductible Single Coverage \$1,800 Family Coverage \$3,600</li> <li>• Coinsurance 75/25%</li> <li>• Maximum Out-of-Pocket Single Coverage \$4,350 Family Coverage \$10,200</li> <li>• Tier 1 Maximum Out-of-Pocket Single Coverage \$4,350 Family Coverage \$10,200</li> <li>• Non-Tier 1 Maximum Out-of-Pocket Single Coverage \$5,350 Family Coverage \$10,200</li> </ul>	<p>Applies to covered charges:</p> <ul style="list-style-type: none"> <li>• DAKOTACARE Provider, In State                             <ul style="list-style-type: none"> <li>○ Tier 1 Providers and Facilities</li> <li>○ Non-Tier 1 Providers and Facilities</li> </ul> </li> <li>• Out-of-state DAKOTACARE Provider</li> <li>• Non-DAKOTACARE Provider *</li> <li>• Out of State PHCS Provider when Member resides out of State *</li> <li>• Non-PHCS Provider when Member resides out of State *</li> </ul> <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>
Out-of-Network	
<ul style="list-style-type: none"> <li>• Deductible Single Coverage \$3,600 Family Coverage \$7,200</li> <li>• Coinsurance 65/35%</li> <li>• Maximum Out-of-Pocket Single Coverage \$8,700 Family Coverage \$21,750</li> </ul>	<p>Applies to covered charges :</p> <ul style="list-style-type: none"> <li>• Non-DAKOTACARE Provider</li> <li>• Out-of-state Provider who is Out of Network</li> <li>• Non-preferred out-of-state provider when services are available in state</li> </ul> <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>

\* Some services require pre-authorization by HMP. HMP must approve the Out-of- Network referral for services to be covered at the Maximum Benefit Level.

Note: Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR and MAC do not apply to the medical out-of-pocket. Call DAKOTACARE at 877.573.7347, option 1 to inquire about your benefit coverage.

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***Medical and Pharmacy  
Out-of-Pocket Maximum***

In-Network \$4,350 per person or \$10,200 per family  
Out-of-Network \$8,700 per person or \$21,750 per family  
Tier 1 \$4,350 per person or \$10,200 per family  
Non-Tier 1 \$5,350 per person or \$10,200 per family

If a Member reaches the medical and pharmacy Out-of-Pocket Maximum, the Plan pays 100% of eligible charges up to the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable charges (UCR) for most eligible expenses for the rest of the Plan Year.

The Medical Out-of-Pocket Maximum **includes**:

- Medical Deductible
- Coinsurance
- Pharmacy

The Medical Out-of-Pocket Maximum **does not include** the following:

- Expenses not covered by the Plan
- Penalties for not receiving Pre-authorization from HMP when required
- Any charges above UCR or MAC