

# FY14 Retiree/COBRA Decision Guide

Annual Enrollment Dates: May 1-15, 2013

## South Dakota State Employee Benefits Program



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# Plan Changes for FY14

## Health Plan

### \$500 Deductible Plan

- Removed all copayments except Emergency Room: \$250
- Increase in Rates
- CVS Caremark replaces Express Scripts, Inc. as the Pharmacy Benefit Manager
- Expanded Tiers of Prescription Drug Coverage to reduce the number of non-covered prescriptions

### \$1,000 Deductible Plan

- Removed all copayments except Emergency Room: \$250
- Increase in Rates
- CVS Caremark replaces Express Scripts, Inc. as the Pharmacy Benefit Manager
- Expanded Tiers of Prescription Drug Coverage to reduce the number of non-covered prescriptions

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

- Increase in Rates
- CVS Caremark replaces Express Scripts, Inc. as the Pharmacy Benefit Manager

## Flexible Benefits

- Increase in Dental Rates
- Increase in Vision Rates

## What to Know about the Health Plans

- You must visit a DAKOTACARE network provider to receive the highest level of benefits.
- In some cases, Health Management Partners must preauthorize services or referrals. To view the Preauthorization Listing visit <http://benefits.sd.gov>, scroll over Forms/Documents and choose Forms/Documents. The Preauthorization 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>.

## \$500 Deductible Health Plan

- You must meet a \$500 per person or a \$1,250 family deductible (family of 3 or more) before the Plan begins paying benefits.
- **Copayment:** Emergency Room \$250 (after deductible)
- 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.

## \$1,000 Deductible Health Plan

- You must meet a \$1,000 per person or a \$2,500 family deductible (family of 3 or more) before the Plan begins paying benefits.
- **Copayment:** Emergency Room \$250 (after deductible)
- 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.

## \$1,800 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-of-pocket-maximum has been met.
- Members must pay for prescription drug expenses which are applied to the deductible. Once the deductible has been satisfied the member pays 25% coinsurance for prescriptions.

### HSA Maximum Contribution for FY14

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 FY14 according to IRS regulations.

	HSA Contribution 2013*
Participant	\$3,250
Participant and spouse, children, or family	\$6,450

\* 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 FY14. 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 FY14						
Plan Details	\$500 Deductible Plan		\$1,000 Deductible Plan		\$1,800 Deductible Plan with HSA	
	Network Provider	Out-of-Network Provider <sup>1</sup>	Network Provider	Out-of-Network Provider <sup>1</sup>	Network Provider	Out-of-Network Provider <sup>1</sup>
<b>Eligible Preventive Services</b>	Covered	65% covered	Covered	65% covered	Covered	65% covered
<b>Plan Year Deductible</b>	• \$500 per person • \$1,250 for family of three or more	• \$1,000 per person • \$2,500 for family of three or more	• \$1,000 per person • \$2,500 for family of three or more		• \$1,800 for single coverage • \$3,600 for family coverage  If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
<b>Copayment</b>	• Emergency Room: \$250 <sup>2</sup>		• Emergency Room: \$250 <sup>2</sup>		N/A	
<b>Coinsurance</b>	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%
<b>Plan Year Out-of-Pocket Maximum <sup>2</sup></b>	\$2,500 (per person)	\$5,000 (per person)	\$3,500 (per person)	\$5,000 (per person)	• \$3,600 single coverage <sup>3</sup> • \$7,200 per family <sup>3</sup>	• \$5,400 single coverage <sup>3</sup> • \$10,800 per family <sup>3</sup>
Prescription Drugs						
<b>Deductible (per person)</b>	\$50	\$50	\$50	\$50	Included in Plan Deductible <sup>3</sup>	
<b>Out-of-Pocket Maximum</b>	• \$1,000 per person • \$2,500 for family of three or more				Included in Plan Out-of-Pocket Maximum <sup>3</sup>	

1 Out-of-network provider means:

- A DAKOTACARE network provider did not provide care; or
- You did not receive approval from Health Management Partners, for a referral to an out-of-network provider; or
- You failed to obtain preauthorization when necessary.

2 The following charges do NOT apply to the out-of-pocket maximum:

- The ER copayment;
- Expenses not covered by the Plan;
- Penalties for not receiving preauthorization from Health Management Partners when required;
- Any charges above usual, customary, and reasonable (UCR) or the allowed Plan maximums.

3 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.

# Prescription Drug Coverage

## How Prescription Drug Coverage Works

- Under the **\$500 Deductible and \$1,000 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.
- 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.
- 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 copay or coinsurance PLUS the difference between the brand name medication and the contracted rate. This cost difference is referred to as an ancillary charge.

Prescription Drug Coverage Under the \$500 Deductible and \$1,000 Deductible Plans		
Tier	30 day supply	31-90 day supply
Tier 1 - Generic	\$7	\$14
Tier 2 - Brand Preferred	\$32	\$50
Tier 3 - Brand Non-Preferred	\$60	\$85
Tier 4 - Specialty Preferred	\$60	N/A
Tier 5 - Specialty Non-Preferred	\$85	N/A

## FY14 Prescription Drug Plan

- Beginning July 1, 2013, CVS Caremark will replace Express Scripts (ESI) as the Pharmacy Benefit Manager (PBM) vendor for the South Dakota State Employee Health Plan.
- Expanded Tiers of Prescription Drug Coverage to reduce the number of non-covered prescriptions.
- The formulary will be available in early May at <http://benefits.sd.gov/annualenrollment.aspx>.
- 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 and devices that are typically developed on DNA-based technologies. These medications and devices require specialized management, monitoring, and/or delivery.
- A comprehensive list of specialty medications can be found at the following link: <http://cvscaremarkspecialtyrx.com/sites/default/files/pdf/SpecialtyDrugs.pdf>

# Retiree Health Plan Contributions

The Health Plan cannot be added during annual enrollment if coverage is not currently in force. However, if coverage is currently in force, dependent(s) can be added to the Plan.

Retiree Monthly Contribution Rates			
Coverage Level	\$500 Deductible Plan Contributions*	\$1,000 Deductible Plan Contributions*	\$1,800 Deductible Plan with HSA Contributions*
Retiree Age as of July 1, 2013**			
≤49	\$499.05	\$372.10	\$302.67
50-54	\$512.95	\$387.68	\$308.13
55-59	\$535.14	\$437.88	\$315.45
60-64	\$548.41	\$473.40	\$321.33
Retiree and 1 Child (Retiree Age as of July 1, 2013)**			
≤49	\$591.67	\$431.03	\$316.98
50-54	\$605.57	\$446.61	\$322.44
55-59	\$627.76	\$496.81	\$329.76
60-64	\$641.03	\$532.33	\$335.64
Retiree and 2 Children (Retiree Age as of July 1, 2013)**			
≤49	\$668.28	\$481.16	\$353.34
50-54	\$682.18	\$496.74	\$358.80
55-59	\$704.37	\$546.94	\$366.12
60-64	\$717.64	\$582.46	\$372.00
Retiree and 3+ Children (Retiree Age as of July 1, 2013)**			
≤49	\$715.21	\$506.45	\$371.66
50-54	\$729.11	\$522.03	\$377.12
55-59	\$751.30	\$572.23	\$384.44
60-64	\$764.57	\$607.75	\$390.32
Retiree, Spouse, and Child(ren) (Retiree Age as of July 1, 2013)**			
≤49	\$783.83	\$583.40	\$504.47
50-54	\$850.45	\$654.08	\$558.42
55-59	\$930.12	\$730.07	\$616.43
60-64	\$999.16	\$780.28	\$654.74

\* \$60 per person per month will be added to your health care contribution if you and/or your covered spouse use tobacco products.

\*\* For changes during the plan year, current age determines contribution rate.

# COBRA

## Health Plan Contributions

The Health Plan cannot be added during annual enrollment if coverage is not currently in force. However, if coverage is currently in force, dependent(s) can be added to the Plan.

COBRA Monthly Contribution Rates			
Coverage Level	\$500 Deductible Plan Contributions*	\$1,000 Deductible Plan Contributions*	\$1,800 Deductible Plan with HSA Contributions*
Participant	\$617.87	\$494.29	\$432.51
Participant and 1 Child	\$706.44	\$550.66	\$446.19
Participant and 2 Children	\$779.70	\$598.58	\$459.84
Participant and 3 or more Children	\$824.58	\$622.77	\$473.47
Participant and Spouse (Spouse Age as of July 1, 2013)**			
< 30	\$728.31	\$571.04	\$460.96
30-39	\$759.69	\$593.84	\$477.53
40-44	\$793.49	\$620.85	\$497.11
45-49	\$826.76	\$650.29	\$518.45
50-54	\$871.56	\$692.11	\$548.72
55-59	\$923.38	\$737.07	\$581.34
60 +	\$968.36	\$766.77	\$602.89
Participant and Spouse and 1 Child (Spouse Age as of July 1, 2013)**			
< 30	\$804.99	\$624.02	\$473.92
30-39	\$837.39	\$644.54	\$491.05
40-44	\$871.80	\$671.94	\$510.64
45-49	\$905.40	\$700.60	\$532.06
50-54	\$947.18	\$741.60	\$562.25
55-59	\$999.83	\$786.52	\$594.89
60 +	\$1,047.08	\$816.27	\$616.51
Participant and Spouse and 2+ Children (Spouse Age as of July 1, 2013)**			
< 30	\$880.90	\$667.28	\$487.59
30-39	\$915.46	\$691.23	\$504.72
40-44	\$949.88	\$717.77	\$524.31
45-49	\$983.43	\$747.82	\$545.73
50-54	\$1,025.21	\$789.54	\$575.92
55-59	\$1,077.91	\$834.54	\$608.56
60 +	\$1,125.15	\$864.25	\$630.18

\* \$60 per person per month will be added to your health care contribution if you and/or your covered spouse use tobacco products.

\*\* For changes during the plan year, current age determines the contribution rate.

## Vision Care Plan

- The Vision Plan cannot be added during Annual Enrollment, if coverage is not currently in force. If coverage is in force, dependent(s) can be added to the Plan.
- The Stand-Alone Vision Plan is provided by Ameritas.
- This is a Stand-Alone Vision Plan and may be purchased in addition to the Dental Fusion Plan that may include limited vision coverage.
- You can see the vision care doctor of your choice.
- The plan pays 100% of the maximum benefit (\$250) for each covered person per plan year.
- Examples of eligible expenses include eye exams, lenses, frames, or contact lenses.
- Questions? Call Ameritas at 800.487.5553 or visit [www.ameritasgroup.com/stateSD](http://www.ameritasgroup.com/stateSD).

COBRA	
Coverage Level	Premium Rates
participant	\$15.54
participant + 1 dependent	\$20.73
participant + 2 dependents	\$28.50
participant + 3 or more dependents	\$37.58

## Life & Accidental Death & Dismemberment (AD&D)

### Supplemental Life Insurance

- Supplemental Life insurance cannot be added during annual enrollment if coverage is not currently in force.
- The Supplement Life insurance ends at the end of your COBRA extension period, (generally 18 months) or on the last day of the month of your 70th birthday, whichever is earlier. There is no conversion policy.
- The State will be launching a new Life Insurance Plan this fall. Please watch your mail for the new Life Insurance information.

Age Group	Contribution Rate Per \$1,000 of Coverage	
	Life	AD&D
Younger than 30	\$0.06	\$0.03
30 to 34	\$0.06	\$0.03
35 to 39	\$0.10	\$0.03
40 to 44	\$0.15	\$0.03
45 to 49	\$0.18	\$0.03
50 to 54	\$0.30	\$0.03
55 to 59	\$0.32	\$0.03
60 to 64	\$0.52	\$0.03
65 to 69	\$1.12	\$0.03
70+	\$2.20	\$0.03

### Accidental Death & Dismemberment (AD&D)

- The AD&D Coverage provides a life benefit in the case of accidental death and dismemberment benefit.
- You must have Supplemental Life Coverage in order to elect AD&D.
- AD&D must equal the Supplemental Life Coverage.

#### Example:

Supplemental Life and AD&D contribution rates are per \$1,000 of coverage. To calculate your contribution amount(s), multiply your current coverage amount by the rate for your age group and then divide by 1,000.

Member - age 46 elects \$38,000 Life and Accidental Death & Dismemberment (AD&D) coverage.

Life Rate = \$0.18 per thousand  $\quad \$38,000 \times 0.18 / 1,000 = \$6.84$  per month

AD&D Rate = \$0.03 per thousand  $\quad \$38,000 \times 0.03 / 1,000 = \$1.14$  per month

# Dental Plans

- 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.
- Network dental providers agree to offer a discount. Out-of-Network dental providers have not agreed to the discount. If the fee exceeds the plan allowance, the difference is the responsibility of the member.
- Ameritas is recruiting dentists to provide more in network dental providers throughout the state.

## FY14 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 10-13.

Dental Plan Comparison Chart										
Plan Details	Base Plan		Enhanced Plan							
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider						
<b>Deductible</b>	\$10 per visit	\$10 per visit	\$25 per visit	\$25 per visit						
<b>Eligible Services</b>	MCE (after deductible)	MCE (after deductible)	U&C (after deductible)	U&C (after deductible)						
<b>Plan Year Maximum Dental and Vision Fusion</b>	<ul style="list-style-type: none"> <li>• \$1,000 dental (per person)</li> <li>• up to \$200 vision (per person)</li> <li>• see Base Plan</li> </ul>		<ul style="list-style-type: none"> <li>• \$1,000 dental (per person)</li> <li>• up to \$200 vision (per person)</li> <li>• see Enhanced Plan</li> </ul>							
<b>Waiting Period</b>	Members can switch between dental plans during Annual Enrollment with no waiting period.		Members can switch between dental plans during Annual Enrollment with no waiting period.							
<b>Orthodontics</b>	\$1,000 lifetime benefit children only under age 19		\$1,500 lifetime benefit adults and children							
<b>Dental Rewards®*</b>	No		Yes <table border="0" style="margin-left: 20px;"> <tr> <td>• Benefit Threshold</td> <td style="text-align: right;">\$500</td> </tr> <tr> <td>• Annual Carryover Amount</td> <td style="text-align: right;">\$250</td> </tr> <tr> <td>• Maximum Carryover</td> <td style="text-align: right;">\$1,000</td> </tr> </table>		• Benefit Threshold	\$500	• Annual Carryover Amount	\$250	• Maximum Carryover	\$1,000
• Benefit Threshold	\$500									
• Annual Carryover Amount	\$250									
• Maximum Carryover	\$1,000									
<b>Adding Coverage</b>	The Dental Plan cannot be added during Annual Enrollment, if coverage is not already in force.  If coverage is in force, dependent(s) can be added to the Plan.		The Dental Plan cannot be added during Annual Enrollment, if coverage is not already in force.  If coverage is in force, dependent(s) can be added to the Plan.							

\* Dental Rewards® apply to the Enhanced Dental Plan only.

- 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 carry over maximum previously established.

## Base Dental Plan

- The Base Dental Plan is provided by Ameritas.
- The 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. There are no coinsurance levels, procedure categories, or percentages with this type of plan.
- The member is responsible for the per visit deductible, charges that exceed the MCE allowance, and any charges over the annual maximum.
- You can visit the provider of your choice and receive benefits but network providers will offer you the maximum level of benefits.
- Individual plan features still apply – 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.
- Questions? Call Ameritas at 800.487.5553 or visit [www.ameritasgroup.com/stateSD](http://www.ameritasgroup.com/stateSD).

COBRA			
Coverage Level	Premiums Rates		
participant	\$25.79		
participant+ 1 dependent	\$46.17		
participant + 2 dependents	\$67.95		
participant + 3 or more dependents	\$83.91		
Maximum & Per Visit Deductible	dental	vision	FUSION®
annual maximum	\$1,000	\$200	\$1,000
per visit deductible	\$10	\$0	\$10/visit dental
Waiting Period			
basic and preventive services	no wait		
major services	1 year waiting period (applies to break in coverage)		
orthodontic services	1 year waiting period (applies to break in coverage)		

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	once every 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	N/A	MCE
restorative composites endodontics (anterior & posterior)	N/A	MCE
denture repair	N/A	MCE
simple extractions	N/A	MCE
anesthesia	N/A	MCE
Major Services	Frequency	Coverage after Deductible
crowns (replacement 1 in 5 years)	N/A	MCE
fixed bridges (replacement 1 in 5 years)	N/A	MCE
dentures (full & partial replacement 1 in 5 years)	N/A	MCE
onlays	N/A	MCE
implants	N/A	MCE
Orthodontic	Frequency	Coverage after Deductible
child only (under age 19)	lifetime max of \$1,000	50%
Vision Summary* \$200 Maximum	Frequency	Allowance
exam	N/A	subject to annual maximum
lenses (glasses and/or contacts)	N/A	subject to annual maximum
frames	N/A	subject to annual maximum

\* Subject to FUSION® plan above

# Enhanced Dental Plan

- The Enhanced Dental Plan is provided by Ameritas.
- The plan pays the listed percentage based on the 75th percentile of U&C 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.
- You can visit the provider of your choice and receive benefits but network providers will offer you the maximum level of benefits.
- Individual plan features still apply – 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.
- Questions? Call Ameritas at 800.487.5553 or visit [www.ameritasgroup.com/stateSD](http://www.ameritasgroup.com/stateSD).

COBRA			
Coverage Level		Premium Rates	
participant		\$43.41	
participant+ 1 dependent		\$75.52	
participant + 2 dependents		\$100.29	
participant + 3 or more dependents		\$135.33	
Maximum & Per Visit Deductible	dental	vision	FUSION®
annual maximum	\$1,000	\$200	\$1,000
per visit deductible	\$25	\$0	\$25/visit dental

Waiting Period	
basic and preventive services	no wait
major services	1 year waiting period (applies to break in coverage)
orthodontic services	1 year waiting period (applies to break in coverage)

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	N/A	80%
restorative composites endodontics (anterior & posterior)	N/A	80%
denture repair	N/A	80%
simple extractions	N/A	80%
peripical X-rays	N/A	80%
sealants	age 15 and under	80%
space maintainers	N/A	80%
full mouth/panoramic X-rays	1 in 5 years	80%
Major Services	Frequency	Coverage after Deductible
crowns/ crown repair (replacement 1 in 5 years)	N/A	50%
fixed bridges (replacement 1 in 5 years)	N/A	50%
dentures (full & partial replacement 1 in 5 years)	N/A	50%
onlays	N/A	50%
implants	N/A	50%
endodontics and periodontics	N/A	50%
anesthesia	N/A	50%
Orthodontic	Frequency	Coverage after Deductible
adult and child	lifetime max of \$1,500	50%
Vision Summary* \$200 Maximum	Frequency	Allowance
exam	N/A	subject to annual maximum
lenses (glasses and/or contacts)	N/A	subject to annual maximum
frames	N/A	subject to annual maximum

\* Subject to FUSION® plan above

# Flexible Benefits

## 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	10.00	19.00	23.00
Out of Network	Preventive	D1110	Cleaning	76.00	n/a	n/a	70.00	6.00	10.00	6.00	70.00
			Total	118.00	n/a	n/a	103.00	15.00	10.00	25.00	93.00
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	-10.00	32.00	33.00	0	10.00	10.00	22.00
Network Dentist	Preventive	D1110	Cleaning	76.00	-12.00	64.00	64.00	0.00	10.00	10.00	64.00
			Total	118.00	-22.00	96.00	97.00	0.00	10.00	10.00	86.00
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	10.00	59.00	75.00
Out of Network	Major	D2740	Crown	872.00	n/a	n/a	357.00	515.00	10.00	515.00	357.00
			Total	1006.00	n/a	n/a	442.00	564.00	10.00	574.00	432.00
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	10.00	24.00	75.00
Network Dentist	Major	D2740	Crown	872.00	-158.00	714.00	357.00	357.00	10.00	357.00	357.00
			Total	1006.00	-193.00	813.00	442.00	371.00	10.00	381.00	432.00

# Flexible Benefits

## 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	42.00	25.00	17.00	100%	17.00	25.00
Out of Network	Preventive	D1110	Cleaning	76.00	n/a	n/a	0	76.00	25.00	76.00	100%	76.00	0.00
			Total	118.00	n/a	n/a	0	130.00	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	-10.00	32.00	n/a	32.00	25.00	7.00	100%	7.00	25.00
Network Provider	Preventive	D1110	Cleaning	76.00	-12.00	64.00	n/a	64.00	25.00	64.00	100%	64.00	0.00
			Total	118.00	-22.00	96.00	0	96.00	25.00	71.00		71.00	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	4.00	130.00	25.00	105.00	80%	84.00	50.00
Out of Network	Major	D2740	Crown	872.00	n/a	n/a	27.00	845.00	25.00	845.00	50%	422.50	449.50
			Total	1006.00	n/a	n/a	0	975.00	25.00	950.00		506.50	499.50
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	25.00	714.00	50%	357.00	357.00
			Total	1006.00	-193.00	813.00	0	813.00	25.00	788.00		416.20	396.80

## Enroll in Benefits: May 1-15, 2013

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 Important Information in FY14.
3. Take Action – Enroll for FY14 Benefits!
  - To make changes, complete the enclosed form and return by May 15, 2013 to the Bureau of Human Resources, Benefits Program.
    - Retiree and COBRA participants cannot enroll online.
  - If you do not enroll/complete the enrollment form during FY14 annual enrollment:
    - Benefit selection(s) will remain the same as you currently have in FY13.

### Benefits Information Available

We encourage you to visit our website at <http://benefits.sd.gov> click RETIREE/COBRA to access benefits information and communications including:

- Latitude Wellness Programs
- Health, Life, and Flexible Benefits Summary Plan Descriptions
- Certain Eligible Preventive Care in the Health Summary Plan Description

If you need further assistance, call the Benefits Program at 877.573.7347, option 2.

### Update Your Mailing Address

- Email [erin.flynn@state.sd.us](mailto:erin.flynn@state.sd.us) - indicate your name, insurance identification number, old address, and new address or
- Call Erin at 877.573.7347, option 2

# 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
<b>Benefits Program</b>			
<ul style="list-style-type: none"> <li>• Health Plan Questions</li> <li>• Enrollment Questions</li> <li>• Life and AD&amp;D Insurance</li> </ul>	Bureau of Human Resources 500 East Capitol Pierre, SD 57501-5070	<a href="mailto:benefitswebsite@state.sd.us">benefitswebsite@state.sd.us</a>  <a href="http://benefits.sd.gov">http://benefits.sd.gov</a>	877.573.7347, option 2 605.773.3148 Fax: 605.773.6840
<b>Latitude Wellness Programs</b>			
<ul style="list-style-type: none"> <li>• Health Assessment</li> <li>• Health Screenings</li> <li>• Health Coaching</li> </ul>	Health Management Partners 2301 West Russell Street Sioux Falls, SD 57105	<a href="mailto:latitude@state.sd.us">latitude@state.sd.us</a>  <a href="http://benefits.sd.gov/Latitude.aspx">http://benefits.sd.gov/Latitude.aspx</a>	877.573.7347, option 3
<b>DAKOTACARE</b>			
<ul style="list-style-type: none"> <li>• Coverage Questions</li> <li>• Provider Network</li> <li>• Claims Processing</li> </ul>	DAKOTACARE P.O. Box 7406 Sioux Falls, SD 57117-7406	<a href="http://www.DAKOTACARE.com">www.DAKOTACARE.com</a>  DAKOTACARE Flex Online <a href="http://www.dakotacareflexonline.com">www.dakotacareflexonline.com</a>  DAKOTACARE Access <a href="http://secure.healthx.com/stsd.asp">http://secure.healthx.com/stsd.asp</a>	800.831.0785 (in-state) 800.628.3778 (out-of-state) Fax: 605.334.8717 (Attn: Claims)
<b>Health Management Partners</b>			
<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Condition Management</li> <li>• Medical Preauthorizations</li> <li>• Medical Management</li> <li>• Our Healthy Baby</li> </ul>	Health Management Partners 2301 West Russell Street Sioux Falls, SD 57105	<a href="http://www.hmpsd.com">www.hmpsd.com</a>	866.330.9886 or 605.333.9886 Fax: 605.731.1905
<b>Ameritas</b>			
<ul style="list-style-type: none"> <li>• Dental</li> <li>• Vision</li> </ul>	Ameritas Group Claims PO Box 82520 Lincoln, NE 68501	<a href="mailto:group@ameritas.com">group@ameritas.com</a>  <a href="http://www.ameritasgroup.com/stateSD">www.ameritasgroup.com/stateSD</a>	800.487.5553 Fax: 402.467.7336

FY14 Retiree/COBRA Decision Guide  
Annual Enrollment Dates: May 1-15, 2013  
877.573.7347, option 2

Published once at a total approximate cost of \$0.38 each for 1500 copies.