ANNUAL ENROLLMENT DATES: MAY 8-22, 2017

FY18 Decision Guide Retiree/COBRA

FY18 (July 1, 2017 - June 30, 2018)

SOUTH DAKOTA
state employee benefits program
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FY18 Decision Guide

South Dakota State Employee Benefits Program

Enroll in Benefits: May 8-22, 2017

Annual Enrollment is May 8-22, 2017. This is the only time during the plan year that you can make changes to your health, dental and vision benefits without a valid family status change.

You must currently have coverage for health, dental, and/or vision to make changes. If you have coverage, you can add your spouse and/or dependent(s) to the plan(s).

You can cancel your health, dental or vision coverage at any time. However, you will not be able to re-enroll in the plans in the future.

If you do not enroll during Annual Enrollment, your health, dental and vision plans will remain the same.

Terminology Check

- DAKOTACARE Network and Sanford providers are all considered in-network providers.
- Since deductible amounts change, the health plans will now be referred to as the Low Deductible Health Plan and the High Deductible Health Plan.
- The preventive drug formulary is a list of prescription drugs prescribed to prevent illness, disease and other health problems for members on the High Deductible Health Plan.
- A **deductible** is the amount that you have to pay before the plan pays anything (other than eligible preventive services).
- A **copayment** is the amount you pay for a given service or prescription.
- **Coinsurance** is the percentage of the costs you pay for any covered expense after you have met your deductible and before reaching the out-of-pocket maximum.

What's new in FY18

• Contribution rates have increased.

• Family status change forms are due to the Bureau of Human Resources within **30 days** following a qualifiying event, such as:

- birth
- adoption
- marriage
- divorce

If you miss the deadline, your next opportunity to add someone to your benefits is during Annual Enrollment for next year.

• The Low Deductible Health Plan deductible will be $850.

• The Low Deductible Health Plan prescription deductible is increasing to $100 per person and copayments will increase by $5. Also, there is a new 60-90 day pharmacy benefit.

• The High Deductible Health Plan generic drugs included on the preventive formulary list will be available to you at no cost. Also, you'll pay a maximum of $90 for a 30-day supply for brand name drugs before you reach your deductible.

• The out-of-pocket maximums for both health plans will increase by $500. See chart on page 4.

• The Annual Maximum Benefit and the Lifetime Orthodontic Benefit on the Enhanced Dental Plan will increase to $2,000.

What you need to know about the Health Plans

• You must visit a DAKOTACARE network or Sanford provider to receive the highest level of benefits.

• Certain pharmacy and medical services must be pre-authorized. To view the Pre-authorization Listing visit http://benefits.sd.gov/forms.aspx under other.

• Eligible preventive care 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 or Sanford 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.

FY18 Health Plan Options

Low Deductible Health Plan ($850)

- The Low Deductible Health Plan deductible is $850.
- The out-of-pocket maximum will increase by $500.
- The prescription deductible is increasing to $100. Also, there is a new 60-90 day pharmacy benefit, and copayments will increase by $5.

High Deductible Health Plan ($1,800 single coverage / $3,600 family coverage)

Health Savings Account (HSA) compatible

- All eligible health plan expenses, including prescription drugs, apply toward the deductible.
- There is an $1,800 deductible for single coverage and a $3,600 deductible for family coverage (per family of two or more).
- If you have family coverage, you will pay $3,600 before the plan pays anything (other than eligible preventive services).
- The out-of-pocket maximum has increased by $500.
- A new preventive formulary for prescriptions has been added.
- An HSA is compatible only with the High Deductible Health Plan and enables you to pay for covered expenses with pretax dollars.
- Retiree/Cobra health plans do not include employer Health Savings Account (HSA) benefits. HSAs established with Discovery Benefits when employed may be continued with a monthly fee. If you don't have an HSA, contact your preferred financial institution to open an account.

HSA MAXIMUM CONTRIBUTIONS	
The following are IRS maximum contributions you can make to an HSA in calendar year 2017.	
Participant only	$3,400
Participant + spouse and/or children	$6,750
* 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 calendar year 2017. Consult your financial planner or accountant for more information.	

You may not be eligible to contribute to an HSA if you:

- are covered by another health plan that is not a qualified High Deductible Health Plan (dual coverage),
- are covered by Tricare,
- are a dependent on someone else's tax return,
- are 65 or older and signed up for Medicare coverage,

or

- have a spouse contributing to a Medical FSA that is not "limited" or "combination."

If you have questions about your HSA eligibility, you should contact your tax consultant.

How Prescription Drug Coverage Works

LOW DEDUCTIBLE HEALTH PLAN

There is a separate $100 deductible (per person, per plan year) for prescription drugs on the Low Deductible Health Plan. Copayments apply after you meet the deductible. If the price is less than the listed copayment, you will pay the lesser of the two amounts.

*Tiered Prescription Drug Coverage	Up to 30 Day Supply Copayment	60-90 Day Supply Copayment
Tier 1 - Generic	$15	$37.50
Tier 2 - Brand Preferred	$45	$112.50
Tier 3 - Brand Non-Preferred	$65	$162.50
Tier 4 - Specialty Preferred	$65	n/a
Tier 5 - Specialty Non-Preferred	$90	n/a

HIGH DEDUCTIBLE HEALTH PLAN

Member pays for eligible prescription drug expenses directly to the pharmacy at the time of service, which then apply to the deductible.

Pharmacy charges are applied to deductible: $1,800 single coverage or $3,600 family coverage per family of two or more.

After the deductible has been met, the member pays 25% coinsurance for covered prescription charges. Coinsurance continues throughout the plan year until the out-of-pocket maximum is met.

HIGH DEDUCTIBLE HEALTH PLAN
NEW! PREVENTIVE FORMULARY DRUG COVERAGE

Prescriptions included on the preventive formulary list available at http://benefits.sd.gov/Forms.aspx will be available to you at a reduced price even before you meet your deductible.

Tiered Prescription Drug Coverage	Up to 30 Day Supply Copayment	60-90 Day Supply Copayment
Tier 1 - Generic	$0	$0
Tier 2 - Brand Preferred	$45	$112.50
Tier 3 - Brand Non-Preferred	$65	$162.50
Tier 4 - Specialty Preferred	$65	n/a
Tier 5 - Specialty Non-Preferred	$90	n/a

- Only prescriptions on the preventive drug formulary list will be available to members of the High Deductible Health Plan at no cost (generic drugs) or you'll pay a maximum of $90 for a 30-day supply for brand name drugs. This is to help you continue to take preventive maintenance drugs before satisfying the deductible.

To see a complete list of prescriptions on the preventive formulary go to http://benefits.sd.gov/FY18AE.aspx under pharmacy.

FY18 Health Plan Comparison

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

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY18				
Plan Details	Low Deductible Health Plan		High Deductible Health Plan with HSA	
	Network Provider[1]	Out-of-Network	Network Provider[1]	Out-of-Network
Eligible Preventive	Covered at 100%	Not covered[3]	Covered at 100%	Not covered[3]
Plan Year Deductible	•$850 per person •$2,125 per family of three or more [4]	•$1,700 per person •$4,250 per family of three or more	•$1,800 single coverage •$3,600 family coverage per family of two or more	•$3,600 single coverage •$7,200 family coverage per family of two or more
			If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
Copayment	•Emergency Room: $250 •Does not count toward your deductible		N/A	
Coinsurance	•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 Year Out-of-Pocket Maximum (includes deductible)	•$4,100 per person •$8,625 per family of three or more	• $7,700 per person •$16,750 per family of three or more	•$4,100 single coverage or any one family member •$8,625 family coverage per family of three or more	•$7,700 single coverage or any one family member •$16,750 family coverage per family of three or more
Prescription Drugs				
Deductible	$100 per person	$100 per person	Included in Plan Year Deductible Preventive maintenance medications may be available at a lower cost. You can find the formulary at http://benefits.sd.gov/forms.aspx	
Pharmacy Out-of-Pocket Maximum	•$1,000 per person •$2,500 per family of three or more		Included in Plan Year Out-of-Pocket Maximum	

[1]DAKOTACARE Network plus Sanford providers make up the South Dakota State Employee Health Plan provider network.

[2]To view eligible preventive care services, visit http://benefits.sd.gov/preventivecare.aspx.

[3]When a covered Dependent attends school out-of-state, or when the member resides out-of-state, Preventive Care services as listed are covered by the plan if member visits a PCHS provider. If member utilizes a non-PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the member's responsibility to pay.

[4]Family deductible must be satisfied by three or more covered members.

FY18 Health Plan Contributions

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

Once enrolled as a COBRA or Retiree Participant, members cannot change the enrollment type. Only the level of coverage may be adjusted during Annual Enrollment.

FY18 RETIREE MONTHLY CONTRIBUTION RATES

Coverage Level	Low Deductible Health Plan	High Deductible Health Plan (HSA Compatible)
Retiree	$1,484.00	$711.97
Retiree + Spouse	$3,241.45	$1,328.98
Retiree + Child(ren)	$1,867.10	$859.27
Family	$3,624.55	$1,476.27

*$60 per person, per pay period will be added to your Health Plan contribution if you and/or your spouse use tobacco products

FY18 COBRA MONTHLY CONTRIBUTION RATES

Coverage Level	Low Deductible Health Plan	High Deductible Health Plan (HSA Compatible)
Participation Only	$585.76	$549.05
Participant + Spouse	$1,265.10	$1,185.41
Participant + Child(ren)	$899.92	$845.30
Family	$1,578.64	$1,481.04

*$60 per person, per pay period will be added to your Health Plan contribution if you and/or your spouse use tobacco products

FY18 Dental Plans

- You cannot add dental coverage during Annual Enrollment. You can only make changes to your current election or cancel your coverage.
- The Base and Enhanced Dental Plans are provided by Delta Dental.
- New this year: The Annual Maximum Benefit and the Lifetime Orthodontic Benefit for new cases (starting after July 1, 2017) have increased to $2,000 on the Enhanced Plan.
- The Base and Enhanced Plans pay for services based on a percentage of allowable charges.
- The member is responsible for the deductible, charges that exceed the covered percentage of allowable charges, and any charges over the annual maximum.
- Delta Dental offers a dental network that includes 98% of the dentists in South Dakota.
- You can visit the dentist of your choice but you may owe less out-of-pocket when you go to a participating/network dentist. Participating/network dentists have agreed to write off charges that exceed the allowable charges; nonparticipating dentists can balance bill those charges to the members.
- Orthodontic cases may be paid over two years based on treatment plan.
- Delta Dental will pay $1,000 for orthodontics in the first year on either plan. In order to receive the additional $1,000 payment in the second year on the Enhanced Plan, the enrollee must continue to be enrolled in the Enhanced Plan.
- Additional dental plan information is available at http://benefits.sd.gov/dental.aspx.
- To find a participating/network dentist, visit www.deltadentalsd.com and click on 'Find a Dentist.'
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Base Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$33.05
Participant + Spouse	$65.99
Participant + Child(ren)	$72.24
Participant + Family	$105.18

Enhanced Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$53.39
Participant + Spouse	$106.59
Participant + Child(ren)	$108.69
Participant + Family	$161.91

Dental Plan Overview

	Base Plan	Enhanced Plan
Annual Maximum	$1,000	$2,000 per covered person
Deductible (per plan year per	$25	n/a
Diagnostic and Preventive Services	no waiting period	no waiting period
Routine and Restorative Services	no waiting period	no waiting period
Major and Orthodontic Services	no waiting period for FY18 one year waiting period after FY18	no waiting period for FY18 one year waiting period after FY18
Maximum Bonus Account (MBA)	n/a	up to $2,000 per Enhanced Plan member

Dental Plan Coverage

Diagnostic & Preventive Services	Frequency	Base Plan Coverage [1]	Enhanced Plan Coverage
Routine examinations	2 per plan year	75%	100%
Routine cleanings	2 per plan year	75%	100%
Bite-wing x-rays	1 per plan year	75%	100%
Full mouth x-ray	1 in 5 years	75%	100%
Fluoride treatments	2 per plan year up to age 19	75%	100%
Space maintainers	on primary posterior teeth up to age 14	75%	100%
Dental sealants	once for unrestored 1st and 2nd permanent molars of child(ren) up to age 16	75%	100%
Routine & Restorative Services	**Frequency**	**Base Plan Coverage [1]**	**Enhanced Plan Coverage**
Emergency treatment	n/a	60%	80%
Non-surgical extractions	n/a	60%	80%
Amalgam (silver) and composite (tooth colored) restorations/fillings	1 every 2 years per surface	60%	80%
Periodontal maintenance	2 per plan yr instead of prophylaxis	60%	80%
Denture repair	n/a	60%	80%
Anesthesia	in conjunction with surgical service	60%	80%
Major Services[2]	**Frequency**	**Base Plan Coverage [1]**	**Enhanced Plan Coverage**
Root canals	1 every 2 years per tooth	35%	50%
Treatment of gum disease (periodontal service)	surgical-once every 3 years nonsurgical-once every 2 years	35%	50%
Crowns/onlays	1 every 5 years per tooth	35%	50%
Bridges	1 every 5 years	35%	50%
Partial and complete dentures	1 every 5 years	35%	50%
Implants	1 every 5 years	35%	50%
Surgical extractions	n/a	35%	50%
Orthodontics[2]		**50% up to**	**50%**
Lifetime orthodontic benefit	paid over the course of treatment plan	$1,000	$2,000[4] (Increased)
Maximum Bonus Account[3]		n/a	$2,000 (Increased)

[1] The covered percentage of allowable charges paid after the deductible has been satisfied.

[2] Members who do not enroll when initially eligible or during Annual Enrollment, will be subject to one year waiting periods for major and orthodontic services in FY19.

[3] Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $1,000 for the plan year. MBA maximum is $2,000 per member.

[4]Only orthodontia treatments started after July 1, 2017 are eligible for the $2,000 lifetime benefit. The previous benefit ($1,500) applies to treatment already in progress.

Dental Maximum Bonus Account (MBA)

DELTA DENTAL®

- Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $1,000 for the plan year.
- The MBA maximum is $2,000 per member.
- You must be enrolled in the Enhanced Plan for one plan year before you can earn MBA benefits.
- You, your spouse and dependents will each have their own account. MBA benefits cannot be shared.
- MBA benefits cannot be used for orthodontic claims.
- Your MBA account balance rolls over year-to-year.
- If you move from the Enhanced Plan to the Base Plan, you will lose your account balance.
- You will also lose your account balance if you have a break in coverage.

Smile Smart for your Health

If you or someone on your dental plan has any of the following health conditions, you/they are eligible for additional benefits (per coverage year) through the Smile Smart for Your Health program.

- Gum (periodontal) disease (4 cleanings*, 2 applications of fluoride varnish)
- Diabetes (4 cleanings*)
- Pregnancy (1 additional cleaning during the time of pregnancy)
- High-risk cardiac conditions (4 cleanings*)
- Kidney failure or undergoing dialysis (4 cleanings*)
- Undergoing cancer-related chemotherapy and/or radiation(4 cleanings*, 2 applications of fluoride varnish)
- Suppressed immune systems (4 cleanings*, 2 applications of fluoride varnish)
- At risk for oral cancer (brush biopsy test for early detection of oral cancer/precancerous cells)

Let your dentist know and he/she will note the condition on your claim form. If you have questions regarding this program call Delta Dental's customer service at 605.224.7345 or 877.841.1478.

* Cleanings can either be a general (prophylaxis) cleaning or a periodontal maintenance cleaning. Periodontal maintenance cleanings are covered under the "Routine and Restorative" category, not the "Diagnostic and Preventive Services" category. Your dentist may or may not charge for exams related to added periodontal maintenance or cleanings. The additional exams are not covered.

Vision Plan

- You cannot add vision coverage during Annual Enrollment, only make changes to your current election or cancel your coverage.
- The Vision Plan is provided by MetLife.
- The Vision Plan covers a wide range of services such as eye exams, glasses, and contact fittings.
- **You must wait one year from your last date of service/purchase before you're eligible to have the same service/purchase covered.**

Coverage Level	Monthly Premiums
Participant	$6.79
Participant + Spouse	$13.61
Participant + Child(ren)	$11.53
Participant + Family	$18.99

- You can see the vision care doctor of your choice but you may pay the lowest out-of-pocket cost if you visit an In-Network provider.
- You can find an In-Network provider by visiting www.metlife.com, selecting menu, vision insurance, 'Find an Eye Doctor,' entering your zip code, and selecting MetLife Vision PPO as the plan.
- Questions? Call MetLife at 800.GET.MET8 (800.438.6388) or 877.573.7347, option 7.

Service	In-Network Coverage	Out-of-Network Reimbursement	Frequency
Exam Comprehensive exam of visual functions and prescriptive corrective eyewear	$10 copay	reimbursed up to $45	12 months after last exam
Materials/Eyewear Copay (either glasses or contact lenses allowed per frequency)	$25 towards frames/lenses and does not apply to elective contact lenses Elective contact lenses are a seperate copayment.	n/a	12 months after last materials/eyewear copay
Lenses			
Single vision	covered after eyewear copay	up to $30 allowance	12 months after last claim
Bifocal	covered after eyewear copay	up to $50 allowance	12 months after last claim
Trifocal	covered after eyewear copay	up to $65 allowance	12 months after last claim
Lenticular	covered after eyewear copay	up to $100 allowance	12 months after last claim
Standard Lens Options Ultra violet coating Polycarbonate (child up to age 18)	covered after eyewear copay	applied to the allowance for the applicable corrective lense	12 months after last claim
Progressive	$55 copay for standard Up to $175 for custom	up to $50 allowance	12 months after last claim
Polycarbonate (adult) Scratch-resistant coating Anti-reflective coating Photochromic	these options are available with "not to exceed" pricing/ maximum copay	applied to allowance for applicable corrective lens	12 months after last claim
Frames[1]	up to $130 allowance after eyewear copay $70 allowance after eyewear copay at Costco	up to $70 allowance	12 months after last claim
Contact Lenses Fitting and Evaluation	standard or premium fit covered in full with a copay up to $60	applied to allowance for contact lenses	12 months after last claim
Elective Contact Lenses (in place of lens & frame benefit)	up to $130 allowance	up to $105 allowance	12 months after last claim
Necessary Contact Lenses (must be medically necessary)	covered after material eyewear copay	up to $210 allowance	12 months after last claim

[1] 20% off the additional amount when patients choose a frame that exceeds the allowance. Available from all In-Network providers except Costco.

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
DAKOTACARE			
• Coverage questions • Provider Network • Claims Processing • Health Homes Questions	DAKOTACARE P.O. Box 7406 Sioux Falls, SD 57117-7606	www.DAKOTACARE.com DAKOTACARE Access https://access.dakotacare.com/?Client=DD10028	800.831.0785 877.573.7347, option 1 Fax: 605.274.3291 (Attn: Claims)
South Dakota State Employee Benefits Program			
• Health Plan Questions • Enrollment Questions	Bureau of Human Resources 500 East Capitol	benefitswebsite@state.sd.us http://benefits.sd.gov	605.773.3148 or 877.573.7347, option 2
Health Management Partners (HMP)			
• Case Management • Condition Management • Medical Pre-authorizations	Health Management Partners 2301 West Russell St.	http://sosd.hmpsdportal.com www.preauthonline.com	866.330.9886 or 877.573.734, option 4 Fax: 605.731.1905
Discovery Benefits			
• Medical Flexible Spending Account • Dependent Care	Discovery Benefits PO Box 2926 Fargo, ND 58108	customerservice@discoverybenefits.com	866.451.3399 or 877.573.7347, option
Delta Dental			
• Dental	Delta Dental PO Box 1157	www.deltadentalsd.com	605.224.7345, 877.841.1478 or
MetLife			
• Vision • Accident	MetLife 200 Park Avenue	www.metlife.com	800.GET.MET8, 800.438.6388 or
Risty Benefits, Inc.			
• Long Term Care-UNUM • Hospital Indemnity-VOYA • Short Term Disability-UNUM • Life Insurance & AD&D - VOYA	Risty Benefits, Inc. 1324 Minnesota Sioux Falls, SD 57105	help@ristybenefits.com www.southdakotaflexbenefits.com	866.237.9411 or 877.573.7347, option 8