SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN
FY16 PLAN YEAR

COBRA - Monthly Premium Rates

DEDUCTIBLE	$750 Ded.	$1,250 Ded.	$1,800 Ded. HSA
PARTICIPANT	$555.95	$536.98	$521.12
PARTICIPANT + SPOUSE	$1,200.74	$1,159.56	$1,125.10
PARTICIPANT + CHILD(REN)	$854.13	$825.91	$802.29
FAMILY	$1,498.33	$1,447.89	$1,405.68

NOTE: Contributions for employee and spouse coverage will increase $60.00 per person per month if you and/or your covered spouse use tobacco.

Rev 4/14/15

DENTAL (Delta Dental) AND VISION PLANS (MetLife) - COBRA
FY16 MONTHLY PREMIUM RATES

DENTAL PLAN - Delta Dental

	BASE PLAN	ENHANCED PLAN
Participant Only	$30.56	$49.35
Participant / Spouse	$61.02	$98.55
Participant / Child(ren)	$66.79	$100.49
Participant / Family	$97.25	$149.70

VISION PLAN - MetLife

Participant Only	$6.53
Participant / Spouse	$13.08
Participant / Child(ren)	$11.08
Participant / Family	$18.26