SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN
FY17 PLAN YEAR
COBRA Monthly Contribution Rates

FY17 COBRA MONTHLY CONTRIBUTION RATES		
Coverage Level	$750 Deductible Plan Contributions*	$1,800 Deductible Plan with HSA Contributions*
Participation Only	$600.89	$563.24
Participant + Spouse	$1,297.79	$1,216.04
Participant + Child(ren)	$923.17	$867.14
Family	$1,619.43	$1,519.30

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

DENTAL - DELTA DENTAL		
	Base Dental Plan Premiums	Enhanced Dental Plan Premiums
Participant	$30.56	$51.33
Participant + Spouse	$61.02	$102.49
Participant + Child(ren)	$66.79	$104.51
Participant + Family	$97.25	$155.69

VISION - METLIFE	
Coverage Level	Monthly Premiums
Participant	$6.65
Participant + Spouse	$13.34
Participant + Child(ren)	$11.30
Participant + Family	$18.63