ANNUAL ENROLLMENT DATES: MAY 6–20, 2016

FY17 Decision Guide Retiree/COBRA

FY17 (July 1, 2016 - June 30, 2017)

SOUTH DAKOTA
state employee benefits program
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FY17 Decision Guide

South Dakota State Employee Benefits Program

Enroll in Benefits: May 6-20, 2016

Annual Enrollment is May 6-20 2016. 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 and are enrolled in the $1,250 Deductible Health Plan, you will be defaulted into the $1,800 Deductible Health Plan.

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

1. What's New in FY17

- New contribution rates.
- Eliminated the $1,250 Deductible Health Plan.
- Lowered the out-of-pocket maximum per member and per family on the $1,800 Deductible Health Plan.
- Added Discovery Benefits as the new Flexible Spending Account and Health Savings Account vendor.
- When you're on the $1,800 Deductible Health Plan, you will only need to pay what you owe for your prescription (deductible or coinsurance amount) at the pharmacy. You will not need to pay the full amount and wait to be reimbursed by DAKOTACARE.

2. Review Your Current Benefit Selections

- Review your personalized confirmation statements(s) enclosed with this Decision Guide.

3. Enroll for FY17 Benefits

- To make changes, complete the enclosed form and return by May 20, 2016 to the South Dakota State Employee Benefits Program.
- If you do NOT enroll/complete the enrollment form during FY17 Annual Enrollment, your benefit selection(s) will remain the same as you currently have in FY16 unless you are on the $1,250 plan. If you are on the $1,250 plan and do not complete the enrollment forms, you will be defaulted into the $1,800 Deductible Health Plan.

What You Need to Know About the Health Plans

- You must visit a DAKOTACARE network 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, select Retiree/Cobra link, scroll over Forms/Documents and choose Forms/ Documents. The Pre-authorization Listing is in the Other section.
- 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 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.
- Expenses not covered by the Health Plan do NOT apply to the deductible or out-of-pocket maximum.
- If you enroll in the $1,800 Deductible Health Plan, there are no prescription drug copayments. Instead, all eligible prescription drug costs must be paid out-of-pocket until you reach your deductible. After you reach your deductible, then 25% coinsurance applies to eligible prescription drug costs.

FY17 Health Plan Options

$750 Deductible Health Plan

- You must meet a $750 per person or a $1,875 family deductible (if you have coverage for a family of 3 or more).
- Copayment: Emergency Room $250.
- 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 copays begin.

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

- All eligible Health Plan expenses, including prescription drugs, apply toward the deductible.
- There is a $1,800 deductible for single coverage and a $3,600 deductible for family coverage (per family of two or more).
- New this year, there is a lower out-of-pocket maximum of $3,600 for single coverage and $8,125 for family coverage with a new provision to cap the maximum when one family member meets $3,600.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies for in-network services until the out-pocket-maximum has been met.

HSA MAXIMUM CONTRIBUTION FOR FY17	
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 2016 according to IRS regulations.	
	HSA Contribution 2016*
Participant only	$3,350
Participant and Spouse, Children or Family	$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 FY17. Consult your financial planner or accountant for more information.	

FY17 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 FY17				
Plan Details	$750 Deductible Health Plan		$1,800 Deductible Health Plan with HSA	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Eligible Preventive Services[1]	Covered at 100%	Not covered[2]	Covered at 100%	Not covered[2]
Plan Year Deductible	• $750 per person • $1,875 per family of three or more	• $1,500 per person • $3,750 per family of three or more	• $1,800 single coverage • $3,600 family coverage	• $3,600 single coverage • $7,200 family coverage
			If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
Copayment	• Emergency Room: $250		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)	• $3,600 per person • $8,125 per family of three or more	• $7,200 per person • $16,250 per family of three or more	• $3,600 single coverage or any one family member • $8,125 family coverage per family of three or more	• $7,200 single coverage or any one family member • $16,250 family coverage per family of three or more
Prescription Drugs				
Deductible	$50 per person	$50 per person	Included in Plan Deductible	
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] To view eligible preventive care services, visit http://benefits.sd.gov/preventivecare.aspx.

[2] 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 PHCS provider. If Member utilizes a non-PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the Member's responsibility to pay.

FY17 Prescription Drug Coverage

How Prescription Drug Coverage Works

$750 DEDUCTIBLE HEALTH PLAN

- A separate prescription drug deductible of $50 per person applies before prescription drug copays begin.

Tiered Prescription Drug Coverage	Up to 30 Day Supply Copay
Tier 1 - Generic	$10
Tier 2 - Brand Preferred	$40
Tier 3 - Brand Non-Preferred	$60
Tier 4 - Specialty Preferred	$60
Tier 5 - Specialty Non-Preferred	$85

$1,800 DEDUCTIBLE HEALTH PLAN

- Member pays for eligible prescription drug expenses directly to the pharmacy at the time of service, which then applies to the deductible.
- After the deductible has been met, the member pays 25% coinsurance for covered prescription charges. Coinsurance continues up to the plan year out-of-pocket maximum.
- New this year, you will pay what you owe for the prescription (deductible or coinsurance amount) at the time of pick-up at the pharmacy. You will not need to pay the full amount and wait to be reimbursed by Dakotacare, if you have met your deductible.
- DAKOTACARE is available to assist you with determining your prescription costs on the $1,800 Deductible Health Plan. During Annual Enrollment, DAKOTACARE can look at your prescription costs from last year and let you know the charges under the $1,800 Deductible Health Plan. Complete the form available at http://benefits.sd.gov/retiree.aspx and return it to DAKOTACARE.
- 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 coinsurance PLUS the difference between the brand name medication and the contracted rate. This cost difference is referred to as an ancillary charge.
- The formulary list is available at http://benefits.sd.gov/formsrc.aspx under the pharmacy section.
- 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 that are typically developed on DNA-based technologies. These medications require specialized management, monitoring and/or delivery. For more information, call DAKOTACARE at 800.831.0785.
- Certain pharmacy and medical services must be pre-authorized. To view the Pre-authorization Listing visit http://benefits.sd.gov, select Retiree/Cobra link, scroll over Forms/Documents and choose Forms/ Documents. The Pre-authorization Listing is in the Other section.

FY17 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.

FY17 RETIREE MONTHLY CONTRIBUTION RATES		
Coverage Level	$750 Deductible Plan Contributions*	$1,800 Deductible Plan with HSA Contributions*
Retiree	$1,044.49	$501.11
Retiree + Spouse	$2,281.44	$935.38
Retiree + Child(ren)	$1,314.13	$604.78
Family	$2,551.08	$1,039.05
* $60 per person, per month will be added to your health plan contribution if you and/or your spouse use tobacco products.		

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.		

FY17 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.
- There is a $25 per plan year, per member deductible for the Base Plan only. There is no deductible 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.
- No more than the noted dental maximum can be applied to dental benefits.
- 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 bill the balance of those charges to the members.
- To find a participating/network dentist, visit www.deltadentalsd.com and click on Find a Dentist.
- 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 $750 for the plan year. MBA maximum is $1,500 per member when enrolled in the Enhanced Plan. Your MBA account balance rolls over year to year.
- Additional dental plan information is available at http://benefits.sd.gov/dental.aspx.
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Base Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$31.78
Participant + Spouse	$63.46
Participant + Child(ren)	$69.46
Participant + Family	$101.14

Enhanced Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$51.33
Participant + Spouse	$102.49
Participant + Child(ren)	$104.51
Participant + Family	$155.69

Dental Plan Overview

	Base Plan	Enhanced Plan
Annual Maximum	$1,000	$1,500
Deductible (per plan year per member)	$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 FY17 1 year waiting period after FY17	no waiting period for FY17 1 year waiting period after FY17
Maximum Bonus Account (MBA)	n/a	up to $1,500 per Enhanced Plan member

Dental Plan Coverage

Diagnostic and 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 and 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 year instead of prophylaxis	60%	80%
Denture repair	n/a	60%	80%
Anesthesia	in-conjunction with surgical service	60%	80%
Major Services	**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	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		50% up to age 19 only	50%
Lifetime orthodontic benefit		$1,000	$1,500
Maximum Bonus Account[2]		n/a	$1,500

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

[2] 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 $750 for the plan year. MBA maximum is $1,500 per member.

Dependent spouses and children who are added to your plan for FY17 will not have waiting periods.

Dental Maximum Bonus Account (MBA)

- 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 $750 for the plan year.
- The MBA maximum is $1,500 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.
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Dental Plan Coverage Examples

Base Plan: Example 1

Example 1 shows a child who had a dental exam, x-rays, cleaning, fluoride treatment, and two dental sealants.

Code	Description	Charged	Approved	DDS Writeoff	Deductible	Covered %	Plan Pays	Patient Pays
D0120	Examination	$50.00	$45.00	$5.00	$25.00	75%	$15.00	$30.00
D0272	Bitewing x-rays (2)	$45.00	$41.00	$4.00	$-	75%	$30.75	$10.25
D1110	Child cleaning	$65.00	$60.00	$5.00	$-	75%	$45.00	$15.00
D1206	Fluoride varnish	$35.00	$35.00	$-	$-	75%	$26.25	$8.75
D1351	Dental sealant	$50.00	$47.00	$3.00	$-	75%	$35.25	$11.75
D1351	Dental sealant	$50.00	$47.00	$3.00	$-	75%	$35.25	$11.75
	Total	$295.00	$275.00	$20.00	$25.00		$187.50	$87.50

Enhanced Plan: Example 1

Example 1 shows a child who had a dental exam, x-rays, cleaning, fluoride treatment, and two dental sealants.

Code	Description	Charged	Approved	DDS Writeoff	Deductible	Covered %	Plan Pays	Patient Pays
D0120	Examination	$50.00	$45.00	$5.00	$0.00	100%	$45.00	$0.00
D0272	Bitewing x-rays (2)	$45.00	$41.00	$4.00	$0.00	100%	$41.00	$0.00
D1110	Child cleaning	$65.00	$60.00	$5.00	$0.00	100%	$60.00	$0.00
D1206	Fluoride varnish	$35.00	$35.00	$-	$0.00	100%	$35.00	$0.00
D1351	Dental sealant	$50.00	$47.00	$3.00	$0.00	100%	$47.00	$0.00
D1351	Dental sealant	$50.00	$47.00	$3.00	$0.00	100%	$47.00	$0.00
	Total	$295.00	$275.00	$20.00	$0.00		$275.00	$0.00

These examples are typical participating/network dental visits. Your dentist may charge more or less than the example.

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.
- Services covered under the Vision Plan are based on the date of service, not plan year.
- 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, clicking on Find a Vision Provider, entering your zipcode, and selecting MetLife Vision PPO as the plan.
- Questions? Call MetLife at 800.GET.MET 8 (800.438.6388).

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

Service	In-Network Coverage	Out-of-Network Reimbursement	Frequency
Exam Comprehensive exam of visual functions and prescriptive corrective eyewear	$10.00 copay	reimbursed up to $45.00	once every 12 months
Materials/Eyewear Copay (either glasses or contact lenses allowed per frequency)	$25.00 towards frames/lenses	n/a	once every 12 months
Lenses			
Single vision	covered after eyewear copay	up to $30.00 allowance	once every 12 months
Bifocal	covered after eyewear copay	up to $50.00 allowance	once every 12 months
Trifocal	covered after eyewear copay	up to $65.00 allowance	once every 12 months
Lent	covered after eyewear copay	up to $100.00 allowance	once every 12 months
Standard Lens Options Ultra violet coating Polycarbonate (child up to age 18)	covered after eyewear copay	not covered	once every 12 months
Progressive	$55.00 copay	up to $50.00 allowance	once every 12 months
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	once every 12 months
Frames[1]	up to $130.00 allowance after eyewear copay $70.00 allowance after eyewear copay at CostCo	up to $70.00 allowance	once every 12 months
Contact Lenses Fitting and Evaluation	standard or premium fit covered in full with a copay up to $60.00	applied to allowance for contact lenses	once every 12 months
Elective Contact Lenses	up to $130.00 allowance	up to $105.00 allowance	once every 12 months
Necessary Contact Lenses (must be medically necessary)	covered after eyewear copay	up to $210.00 allowance	once every 12 months

[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
Benefits Program			
• Health Plan Questions • Enrollment Questions	Bureau of Human Resources 500 East Capitol Pierre, SD 57501	benefitswebsite@state.sd.us http://benefits.sd.gov	605.773.3148 Fax: 605.773.6840
DAKOTACARE			
• Coverage Questions • Provider Network • Claims Processing	DAKOTACARE P.O. Box 7406 Sioux Falls, SD 57117-7406	www.DAKOTACARE.com DAKOTACARE Access https://access.dakotacare.com/?Client=DD10028	800.831.0785 Fax: 605.336.0270 (Attn: Claims)
Health Management Partners			
• Case Management • Condition Management • Medical Pre-authorizations • Medical Management • Our Healthy Baby	Health Management Partners 2301 West Russell St. Sioux Falls, SD 57105	https://sosd.hmpsdportal.com/ www.preauthonline.com	866.330.9886 Fax: 605.731.1905
Delta Dental			
• Dental	Delta Dental PO Box 1157 Pierre, SD 57501	www.deltadentalsd.com http://benefits.sd.gov/dental.aspx	605.224.7345 or 877.841.1478
MetLife			
• Vision	MetLife 200 Park Avenue New York, NY 10166	www.metlife.com http://benefits.sd.gov/vision.aspx	800.GET.MET8 or 800.438.6388
APS Employee Assistance Program (EAP) for COBRA members			
• Family Issues • Alcohol/Drugs • Anxiety • Parenting • Workplace • Managing Stress • Aging • Depression • Grief • Relationships • Abuse • Legal	APS 7125 Columbia Gateway Dr. Suite 250 Columbia, MD 21046	www.apshelplink.com company code: southdakota 24 hours a day, 7 days a week	800.713.6288
Discovery Benefits (effective July 1, 2016)			
• Flexible Spending Accounts • Health Savings Account • Health Reimbursement Account	Discovery Benefits PO Box 2926 Fargo, ND 58108	customerservice@discoverybenefits.com www.discoverybenefits.com	866.451.3399