



SD School for the Blind and Visually Impaired

APPENDIX VII: EMPLOYEE & EMPLOYER PAID BENEFITS

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HEALTH INSURANCE - South Dakota Public Employee Benefit Program

All permanent full-time/part-time employees are covered as long as they are employed by the SDSBVI. Coverage begins one month and one day from the date of hire. New hires must make all benefit election choices within 30 days of hire. Failure to enroll during this time will result in an 18-month waiting period for coverage to be effective. See below for more information on Late Enrollees. All employees and spouse members of the State Health Plan are required to complete a Health Assessment (HA) at <https://www.hcmti.com/hra/index2.aspx>. Failure to complete the Health Assessment will result in a reduction of benefits. The state provides four (4) health care coverage plans (\$300 Deductible, \$1,000 Deductible, \$2,000 Deductible, and Opt-Out Option). These health coverage plans run from July 1 through June 30 of each year. The employee chooses the one right for them. The state's health plan is self-insured. The state purchased a repricing, pre-authorization, managed care service and claims processing from Dakota Care. There is 75/25 coinsurance on all eligible expenses after the deductible or copayment has been met. This means that your insurance pays 75 percent and you pay 25 percent whenever you utilize a Dakota Care provider. When utilizing a Non-Dakota Care provider the co-insurance is 65/35. Employees and/or their spouse who use tobacco products will be charged a \$60 per person per month rate for their health insurance coverage. The State reserves the right to verify the use of tobacco products of you and/or your spouse during the plan year. If you misrepresent yourself and/or your spouse, you could face disciplinary action and the reduction or loss of your health and life benefits.

As a tobacco user you are encouraged to participate in the South Dakota Quitline at 1-866-SD-Quits; for addition information online www.healthysd.gov/QuitTobacco.html. If you quit on your own, you may change the Tobacco Use designation through the Annual Enrollment Process or by sending BOP a written statement of no tobacco use for the past 120 days or more.

The 12-month pre-existing conditions clause is waived if you and/or your dependents were covered by a qualifying health plan for at least 12 consecutive months prior to your hire date. You must provide the Bureau of Personnel with proof of creditable coverage in the form of a Certificate of Prior Coverage from your previous employer or group health plan or letter from your prior group health plan. A pregnancy existing on the effective date of coverage is not a pre-existing condition covered under this policy.

Since the state's health plan is self-insured we do not have group numbers or plan numbers. Your policy number/identification number will be assigned by Dakota Care.

New employees must enroll within 30 days of date of hire. Enroll online at www.BOPweb.com.

LATE ENROLLEES

When an employee applies to add a dependent (or himself/herself) to the health plan after the initial 30 day enrollment period as a new hire, that dependent (or employee) is considered a late enrollee. The dependent (or employee) cannot be added to the plan until an 18-month waiting period is satisfied. BOP staff will track late enrollee applicants, but it is the employee's responsibility to re-apply for coverage when the end of the 18-month waiting period is approaching.

ID CARDS

Dakota Care is responsible for issuing our health plan ID Cards. These ID Cards are not automatically sent to everyone at the beginning of a plan year. New ID Cards are issued if one or more of the following occurs:

- Change from a Deductible Plan to a Provider Plan (or visa versa)
- Change your Primary Care Provider
- Add or drop a dependent from the plan
- Your name changes

If you lost your card or need an extra card, contact Dakota Care at 1-800-831-0785.

MRI & CT SCANS

The State has contracted with various South Dakota hospitals and surgery centers to accept a fix fee for MRIs and CT Scans. (Please contact the Director of Human Resources or go online at www.BOPweb.com to receive a list.) MRIs and CT Scan tests are covered up to a set payment amount. The set payment amount covers the cost of the test only. This means that you, the member, will not have to pay out-of-pocket deductibles, copayments or coinsurance amounts for the test, whether you are a member of the \$300 Deductible Plan, the \$1000 Deductible Plan, or the \$2000 Deductible Plan. The reading of the MRI and CT Scan, or any other services or medical components that may be associated with the test (such as injection of the dye), will be handled in the standard manner in that the deductible, if any, must be met, or a co-insurance amount of 25 percent of the Dakota Care negotiated rate will need to be paid by the member. MRIs and CT Scans received from NONCONTRACTED Facilities will be paid at the following rates.

Non-Emergency Plan will pay 75 percent of the test up to \$450 for a CT Scan and \$775 for an MRI. Plan members will pay the deductible, if any, and/or all of the remaining amount, less any negotiated discounts. (Example: If the cost of the CT Scan is \$835 at a non-contract facility, the plan would pay \$450 of that amount and the member would be responsible for the remainder through deductibles and co-insurance amounts which would be \$385 in this example.). Emergency Plan will pay 75 percent of the test. Member will pay deductible, if any, and/or all of the remaining amount. Each emergency MRI or CT Scan will be reviewed to determine if it has been appropriately classified as an emergency.

ASK MAYO CLINIC (24-HOUR NURSELINE)

Ask Mayo Clinic is a health information service line provided by one of the most respected healthcare providers. This service will provide you with quality healthcare and reliable health information 24 hours a day. You can call them toll free anywhere in the United States at 1-877-284-7339 (TDD: 1-877-728-3311)

QUICK CLICK MD

To receive medical information from a physician, State employees are now able to access Quick Click MD by direct e-mail to quickclickmd@yahoo.com. As a covered member of the State Self-Insurance Plan, you can utilize this service to obtain medical information. An e-mail response will be sent to you within 3-7 business days.

OUT-OF-STATE PREFERRED PROVIDER

The State of South Dakota Employee Health Plan will require all out-of-state care for inpatient and outpatient services to be authorized by HCMTI (Health Care Medical Technology Inc.). All requests for out-of-network referrals must be made prior to receiving care from the provider in order for you to receive the highest level of benefits (75%/25%).

Treatment received at the Mayo Clinic and facilities in Rochester, MN and the University of Colorado and facilities in Denver, CO will no longer be self-referral. An out-of-state preauthorization is required prior to services being received from these facilities.

Out-of-network benefits (65%/35%) will be applied to services received out-of-state if out-of-state care is not preapproved by HCMTI.

For preauthorization of services, providers should contact HCMTI via an online process at www.preauthonline.com. Contact the BOP, Division of Health, at 605-773-3148 if you have any questions.

Emergency Care – When traveling out-of-state and emergency services are required, a call to HCMTI must be made within 48 hours to retro-authorize an in-patient admission (866-330-9886 or 605-333-9886).

Dependents Residing In Other States – There are no changes to authorization requirements for dependents (college students) residing in other states.

BOP WEBSITE: www.BOPweb.com

By using the index on the homepage of BOPweb.com you will find answers to all your benefit questions. Some examples:

- Latest Benefit Newsletter
- Q/A: Answers to frequently asked benefit questions
- Glossary: Definitions to benefit terminology
- About You
 - Total Compensation (shows value of benefits provided by employer)
 - Personal Information
 - Total Cash Compensation
 - Benefits you are currently enrolled in.

TAMIFLU OR RELENZA MAY BE COVERED

As an insured with the State Health Plan – you, your spouse or dependents may be eligible for reimbursement of Tamiflu or Relenza. The flu vaccination is a common approach to minimizing the affects of influenza. Sometimes members that receive the flu vaccination may acquire the influenza virus. For these rare instances, the State Health Plan is allowing the coverage of Tamiflu or Relenza, if the following criteria are met:

- **You have received the flu vaccine.**
- **You have retained the yellow copy of the “[Consent for Flu Vaccination](#)” form.**
When attending the Flu Vaccine Clinic, the Department of Health provides the yellow copy to all members receiving the vaccine. Proof must be provided to the Division of Benefits prior to reimbursement of the Tamiflu or Relenza.

- **You have been prescribed Tamiflu or Relenza.**

Prior to filling the prescription for Tamiflu or Relenza, you should contact the Division of Benefits at 773-3148 when possible, to verify coverage available to you. If you are filling the prescription during non-business hours, your payment (less any deductibles or co-pays) to the pharmacy will be reimbursed if you meet the requirements.

Please contact the Division of Benefits at 773-3148 with any questions.

OPT-OUT OPTION

Employees may elect to opt-out of the state's health plan during a Flex Enrollment Period. They must provide proof that they are covered by another group health plan. One may opt back into the state's health plan during the annual enrollment period. If an employee wants back in during the plan year, they will need to provide proof that through no fault of their own their other coverage has been lost. Without a qualified change they must wait until the annual enrollment period. Employee will receive a \$300 incentive credit for electing to opt-out of the state's health plan.

\$300 DEDUCTIBLE PLAN

	Dakota Care Provider	Out of Network Care
COVERED:	Employee Only	Employee Only
CERTAIN ELIGIBLE PREVENTATIVE SERVICES	100% Coverage	65% Coverage
DEDUCTIBLE	\$300 per person \$750 per family of 3 or more	\$1000 per person \$2500 per family of 3 or more
COINSURANCE: (coinsurance applies after you meet your deductible and after any copayment)	Plan pays: 75% after copayment 100% for selected preventive care You pay: 25% or less of eligible charges	65% / 35%
MAXIMUM OUT OF POCKET:	\$2500	\$5000
CLAIMS FILED:	None	By Dakota Care provider to Dakota Care. By employee to Dakota Care if non-Dakota Care provider.
LIFE TIME MAXIMUM	Two Million Dollars	

Copayments do not apply to the annual out-of-pocket maximum. Copayments for outpatient surgery, MRI and CT scans will no longer be waived based on provider or facility used.

In many cases, the most you pay is an office visit copayment at the time you receive eligible preventive care. You pay \$30 when you see your Dakota Care Provider, or \$40 when you visit an approved specialist. The Plan pays the balance of other office visit charges. The Plan also pays 75% of the professional and ancillary charges associated with that visit. (Ancillary charges include services like lab work, x-rays and blood work.)

	<u>Copayment</u>
Dakota Care Provider	\$ 30
Specialty Care	\$ 40
CT Scan	\$100
Emergency Room	\$200
MRI	\$200
Surgical Center	\$400
Outpatient Fee	\$450
Inpatient Fee	\$550
Physical Therapy	\$ 15
Chiropractic	\$ 20

The \$300 Deductible Plan covers certain preventive care services, when provided by your Dakota Care Provider or an approved specialist.

Covered preventive services include:

- Prenatal (maternity) Care for you and your covered spouse
- Well Child Care
- Immunizations
- Cancer Screenings:
 - Office Visits
 - Scheduled Mammograms
 - Annual Pap Smears
 - Prostate Screening (PSA) Test
 - Colonoscopies
 - Sigmoidoscopies
 - Cost of Procedures
 - Ancillary Fees
 - Biopsies Fees
 - Lab Fees
 - Pathology Fees
 - Physician Services
 - Reading/Interpretive Fees
 - Testing Fees

Prenatal Care -- The Plan covers prenatal office visits, lab fees and other ancillary services for you or your covered spouse, according to the following schedule. (Ultrasounds are not covered by the Plan unless medically necessary. When medically necessary, ultrasounds are covered at 75 percent. You pay 25 percent of the maximum charges allowed by the Plan for that service.) More frequent visits will be allowed. However, you will pay office visit copayments for the extra visits. These are not included in the “global” fees shown below. In addition, the Plan will cover lab services and other necessary procedures for the additional visits at 75 percent. You will pay 25 percent of the extra fees. Your share of the cost for normal maternity care will be capped at \$300 (care from your Dakota Care Provider), or \$400 (OB-GYN services). These maximum charges are your “global” maternity fees. Global fees refer to the services that are normally provided as part of a maternity “package.”

Well Child Care -- Well childcare is covered at 100 percent through age 6, when received according to the following schedule. This includes office visits, lab fees and childhood immunizations. There is no office visit copayment for these services.

AGE	FREQUENCY
Birth - 12 months	5 exams (between birth - 2 months, 2, 4, 6 & 9 months)
1 - 2 years	2 exams
2 - 6 years	Annually

The \$300 Deductible Plan also covers immunizations at 100 percent.

Mammograms / Pap Smears - The Plan covers 100 percent after you pay an office visit copayment. For women age 40 and over, the health plan now covers one mammogram every plan year.

Prostrate Screening - After age 50 tests are covered at 100 percent after an office visit copayment.

Colonoscopies / Sigmoidoscopies - After age 50 annual exams are covered at 100 percent.

\$1000 DEDUCTIBLE

	Dakota Care Provider	Non-Dakota Care Provider
COVERED:	Employee Only	Employee Only
CERTAIN ELIGIBLE PREVENTATIVE SERVICES	100% Coverage	65% Coverage
DEDUCTIBLE:	\$1000 per person \$2500 per family of 3 or more	\$1000 per person/ \$2500 per family of 3 or more
COINSURANCE:	75/25	65/35
MAXIMUM OUT OF POCKET:	\$3500	\$5000
CLAIMS FILED:	By Doctor to Dakota Care	By Employee directly to Dakota Care
LIFE TIME MAXIMUM	Two Million Dollars	

The \$1000 Deductible Plan covers certain preventive care services, when provided by your Dakota Care Provider or an approved specialist. Remember, certain eligible preventive services are covered at 100% when using a network provider – without having to pay a deductible.

Covered preventive services include:

- Prenatal (maternity) Care for you and your covered spouse
- Well Child Care
- Immunizations
- Cancer Screenings:
 - Office Visits
 - Scheduled Mammograms
 - Annual Pap Smears
 - Prostate Screening (PSA) Test
 - Colonoscopies
 - Sigmoidoscopies
 - Cost of Procedures
 - Ancillary Fees
 - Biopsies Fees
 - Lab Fees
 - Pathology Fees
 - Physician Services
 - Reading/Interpretive Fees
 - Testing Fees

Prenatal Care -- The Plan covers prenatal office visits, lab fees and other ancillary services for you or your covered spouse, according to the following schedule. (Ultrasounds are not covered by the Plan unless medically necessary. When medically necessary, ultrasounds are covered at 75 percent. You pay 25 percent of the maximum charges allowed by the Plan for that service.) More frequent visits will be allowed. However, you will pay office visit copayments for the extra visits. These are not included in the “global” fees shown below. In addition, the Plan will cover lab services and other necessary procedures for the additional visits at 75 percent. You will pay 25 percent of the extra fees. Your share of the cost for normal maternity care will be capped at \$300 (care from your Dakota Care Provider), or \$400 (OB-GYN services). These maximum charges are your “global” maternity fees. Global fees refer to the services that are normally provided as part of a maternity “package.”

Well Child Care -- Well childcare is covered at 100 percent through age 6, when received according to the following schedule. This includes office visits, lab fees and childhood immunizations. There is no office visit copayment for these services.

AGE	FREQUENCY
Birth - 12 months	5 exams (between birth - 2 months, 2, 4, 6 & 9 months)
1 - 2 years	2 exams
2 - 6 years	Annually

The \$1000 Deductible Plan also covers immunizations at 100 percent.

Mammograms / Pap Smears - The Plan covers 100 percent after you pay an office visit copayment. For women age 40 and over the health plan now covers one mammogram every plan year.

Prostrate Screening - After age 50 tests are covered at 100 percent after an office visit copayment.

Colonoscopies / Sigmoidoscopies - After age 50 annual exams are covered at 100 percent.

Once you have reached the out-of-pocket maximum, for most covered expenses your plan pays 100 percent for the rest of the plan year up to a lifetime maximum of \$2,000,000.

\$2000 DEDUCTIBLE

	Dakota Care Provider	Non-Dakota Care Provider
COVERED:	Employee Only	Employee Only
CERTAIN ELIGIBLE PREVENTATIVE SERVICES	100% Coverage	65% Coverage
DEDUCTIBLE:	\$2000 per person	\$2000 per person
All eligible charges are included (prescription drugs as well). Family deductible must be made to pay any benefits.	\$4000 per family	\$4000 per family
COINSURANCE:	75/25	65/35
MAXIMUM OUT OF POCKET:	\$4000 per person	\$ 6000 per person
All eligible charges are included (prescription drugs as well). Family deductible must be made to pay any benefits.	\$8000 per family	\$12000 per family
CLAIMS FILED:	By Doctor to Dakota Care	By Employee directly to Dakota Care
LIFE TIME MAXIMUM	Two Million Dollars	

The \$2000 Deductible Plan covers certain preventive care services, when provided by your Dakota Care Provider or an approved specialist. Remember, certain eligible preventive services are covered at 100% when using a network provider – without having to pay a deductible.

Covered preventive services include:

- Prenatal (maternity) Care for you and your covered spouse
- Well Child Care
- Immunizations
- Cancer Screenings:
 - Office Visits
 - Scheduled Mammograms
 - Annual Pap Smears
 - Prostate Screening (PSA) Test
 - Colonoscopies
 - Sigmoidoscopies
 - Cost of Procedures
 - Ancillary Fees
 - Biopsies Fees
 - Lab Fees
 - Pathology Fees
 - Physician Services
 - Reading/Interpretive Fees
 - Testing Fees

Prenatal Care -- The Plan covers prenatal office visits, lab fees and other ancillary services for you or your covered spouse, according to the following schedule. (Ultrasounds are not covered by the Plan unless medically necessary. When medically necessary, ultrasounds are covered at 75 percent. You pay 25 percent of the maximum charges allowed by the Plan for that service.) More frequent visits will be allowed. However, you will pay office visit copayments for the extra visits. These are not included in the “global” fees shown below. In addition, the Plan will cover lab services and other necessary procedures for the additional visits at 75 percent. You will pay 25 percent of the extra fees. Your share of the cost for normal maternity care will be capped at \$300 (care from your Dakota Care Provider), or \$400 (OB-GYN services). These maximum charges are your “global” maternity fees. Global fees refer to the services that are normally provided as part of a maternity “package.”

Well Child Care -- Well childcare is covered at 100 percent through age 6, when received according to the following schedule. This includes office visits, lab fees and childhood immunizations. There is no office visit copayment for these services.

AGE	FREQUENCY
Birth - 12 months	5 exams (between birth - 2 months, 2, 4, 6 & 9 months)
1 - 2 years	2 exams
2 - 6 years	Annually

The \$2000 Deductible Plan also covers immunizations at 100 percent.

Mammograms / Pap Smears - The Plan covers 100 percent after you pay an office visit copayment. For women age 40 and over the health plan now covers one mammogram every plan year.

Prostrate Screening - After age 50 tests are covered at 100 percent after an office visit copayment.

Colonoscopies / Sigmoidoscopies - After age 50 annual exams are covered at 100 percent.

The \$2,000 Deductible Plan (HSA Compatible) option is designed as a high deductible health program. If you elect this plan option, you have the opportunity to participate in a new type of health benefit program called a Health Savings Account (HSA). To set up a Health Savings Account (HSA), please contact any bank, insurance company, or a financial institution to act as the HSA trustee or custodian.

Then choosing the \$2000 Deductible Plan (HSA Compatible) option includes:

- All eligible expenses, INCLUDING prescription drugs will apply to the deductible.
- An annual \$4,000 deductible per family. The family deductible (\$4,000) must be met by one or more individuals before any benefit will be paid.
- Preventive services covered under the Deductible Plan are routine mammogram screenings per schedule and PSA tests at age 50. These eligible services will apply to the \$2,000 deductible.

Employees selecting the \$2000 health care coverage plan will receive special dollars "flex credits" (\$300). These flex credits will be put into a Medical Expense Spending Account (\$25 monthly). If an employee is contributing to a Medical Spending Account, these flex credits can help reduce the monthly contributions. Flex Credits must be used up before the end of the plan year (June 30). Employees have a 2 ½ month grace period, September 15, to spend or incur claims related to their account. If both you and your spouse are state employees, you can no longer "transfer" any flex credits to your spouse.

Coverage for a spouse and/or children is available under all plans. You enroll your dependents in the same medical plan you select. Qualified dependents include your spouse, if not divorced or legally separated from you, and your unmarried, dependent children up to age 19 who are not employed on a full-time basis. Dependent children who are full-time students are covered up to age 25. (See the Director of Human Resources for the group rates.) Each fall and spring semester a request for student verification will be sent to the employee from BOP. Failure to complete will result in claim denial as well as termination of dependent coverage. Coverage does go into effect one month and one day after employment.

PRE-ADMISSION NOTIFICATION: When going to a Dakota Care Provider no pre-authorization calls need to be made by the employee. The Provider makes the call. If an employee goes to a Non-Dakota Care Provider, the employee must notify Dakota Care when pre-authorization is needed by calling 1-800-831-0785 (in state); 1-800-628-3778 (out of state). This call needs to be made before scheduled treatments or hospitalizations and within 48 hours of an emergency admission. If you do not make this toll-free call when utilization review is needed, you will be responsible for the first \$500 of expenses, regardless of the amount of deductible or coinsurance already met.

Spouses or dependents of employees who have primary coverage under another health plan and secondary coverage under the state's plan is subject to deductibles and copayments on covered charges under the coordination of benefit provisions between primary and secondary plans.

INCENTIVE PROGRAMS

1. BILLING ERROR INCENTIVE

Employees who discover billing errors from medical providers may receive an incentive payment. The incentive payment to the employee will be 50 percent of the verified savings to the plan (deductible excluded) with a minimum and maximum payment of \$25 - \$1000 per occurrence. To qualify for the Billing Error Incentive payment you must send a good, readable copy of both the incorrect bill and the corrected bill to Gary Zimmerman at the Bureau of Personnel, 500 E. Capitol, Pierre, SD 57501.

Highlight the errors and send along a brief explanation. This will help to confirm and verify the error.

2. OUR HEALTHY BABY

Qualified plan participants will be offered a \$100 US Savings Bond. The intent is to help bring pregnancies which are covered by the state's health plan to full term, and hopefully prevent the high costs of premature births. To qualify for this incentive, expectant parents who are covered by the plan must call Dakota Care (1-866-821-2242) or go online at www.ourhealthybaby.com within the first trimester of pregnancy. When you add the new child to the State's Health Plan you will receive the \$100 US Savings Bond.

3. HOSPITALIZATION INCENTIVE PROGRAM

The plan has contracted with various hospitals to participate in a risk sharing arrangement known as DRG-based payment. Hospitals that participate in this arrangement agree to accept a prenegotiated fixed fee for in-patient services performed. The plan may, in certain instances, offer an incentive to employees and covered dependents to utilize hospitals participating in the DRG pricing methodology. Incentives may include the waiving of all or a portion of applicable deductibles, copayments, co-insurance amounts, or out-of-pocket payments normally made by a member. Participation in this incentive program is entirely voluntary and the member will never be required to pay more than they would have paid under other plan provisions. The Bureau of Personnel reserves the right to select those employee and covered dependent hospitalizations to participate in this incentive program and determine the applicable incentive to be offered. Contact Dakota Care (1-800-831-0785) for more information and to see if you qualify.)

4. WELLNESS PROGRAMS:

A. Health Screening

Current employees who are covered under the State's Health Plan as well as their covered spouse are eligible to participate in the health screening. Eligible members are allowed to attend one health screening event per plan year. These screenings are offered free of charge.

Qualified healthcare professionals will conduct the health screenings. The tests include cholesterol, blood pressure, HbA1c test, body mass, and carbon monoxide. The HbA1c test will help to discover members who are at risk for diabetes. Healthcare professionals will review the results of the tests with you before you leave. Health Care Medical Technology Inc. (HCMTI) manages the high-risk component of the screenings and will contact those members whose screening results suggest follow up in disease management.

For questions regarding this benefit, visit www.bopweb.com. Visit www.myflexonline.com or call 1-800-831-0785 for information regarding your Health Risk and Wellness Account.

B. Healthy Employees Wellness Program

Current employees and their covered spouses may register in the Healthy Employees Wellness Program by logging on to <https://healthyemployees.sd.gov>. You can elect to either tax or not tax the \$100 credit that is deposited into the Health Risk and Wellness Account (HRWA). You will make this election by logging onto <https://healthyemployees.sd.gov> and choose whether to tax or not tax the credit.

If you choose not to tax the credit, you may be reimbursed for out of pocket medical expenses such as copayments, deductibles and co-insurance. Medical expenses which are eligible for reimbursement are generally those described under the Internal Revenue Code. The expenses must be incurred within your period of coverage within the Plan Year (June 30). Employees have a 2 ½ month grace period, September 15, to spend or incur claims related to their account. If you have a Medical Expense Spending Account, that account must be depleted before you can access your HRWA. The money will be reimbursed to you from Dakota Care through one-stop claims processing, after you have depleted your Medical Expense Spending Account. Out of pocket medical expenses that are not processed by Dakota Care such as prescription copayments must be submitted using the standard claim form and checking the box that says "Health Risk and Wellness Account".

By electing to tax your HRWA credit, you may request reimbursement for exercise equipment, fitness and nutrition center fees such as YMCA, Curves, Pace or Weight Watchers, or Game, Fish & Parks park entrance licenses. You must submit a manual claim for reimbursement directly to Dakota Care. By electing to tax the credit, any unused balance in the account can rollover from one Plan Year to the next for a period of up to two years. It is best to request reimbursement within a reasonable timeframe to ensure you receive proper reimbursement.

The Healthy Employees Wellness Program is a confidential statewide wellness program that provides you the tools to become more physically fit and healthier, including:

- A personal diary that allows you the option of creating nutritional or physical goals, updating various logs (exercise, nutrition, or weight log) or viewing a progress report,
- The ability to view your most recent or prior health screening, and
- The options to view and update your personal information.

In addition, just for joining the program you are also registered to receive free gifts such as caps, t-shirts, sweatshirts, polo shirts, shorts, sweatpants, fleece blankets, Nalgene[®] water bottles, pedometers, Walkmans, gym bags, or briefcases. Then, as you reach your goals, you will be able to choose a gift from a specific category within the online gift store catalog. Visit www.myflexonline.com or call 1-800-831-0785 for information regarding your Health Risk and Wellness Account.

5. DIABETES MANAGEMENT PROGRAM

State Health Plan members who are identified as diabetic are invited to participate in a diabetes management program. As an incentive for your participation, you will receive a free Accu-Chek Compact[®] Blood Glucose Monitor to check your blood sugars. In addition, the following diabetic-related expenses will be covered at 100 percent* by the State's Health Plan:

- Office visits (four total per Plan Year)
- HbA1c test
- Cholesterol Lipid Profile
- Blood Pressure Check
- Fasting Blood Sugar

*You will be responsible for additional costs related to routine tests or lab work.

The four free office visits during the Plan Year consist of:

- Three routine visits to your physician, paid at 100 percent by the State's Health Plan.
- One scheduled appointment at a health screening event sponsored by the State's Health Plan.

Participants who are covered under the \$300 Deductible must continue to follow the rules of this plan for the highest level of benefits. Contact Health Care Medical Technology at 1-866-330-9886 or online at: www.dbnurse@hcmti.com for more information.

6. DISEASE MANAGEMENT AND OTHER FOLLOW-UP PROGRAMS

If you or your covered spouse has been identified as having a chronic condition or as high-risk for certain conditions, you are invited to join special follow-up programs offered through the State's Group Health Plan.

You have access to a number of services designed to help you reduce health risks and improve the quality of self-care at home:

- Your State of Health
- HEALTHWISE
- Ask Mayo Clinic
- Other online resources such as "Quick Click MD"

Contact the Bureau of Personnel at 605-773-5634 for more information.

7. ONCOLOGY HEALTH MANAGEMENT PROGRAM

Health Care Medical Technology Inc. (HCMTI) has developed an Oncology Health Management Program for the State's Health Plan. The purpose of this program is to assist those members with a cancer diagnosis in addressing concerns of medical care.

HCMTI's Oncology Health Management Program is designed to:

- Improve access to quality health care.
- Coordinate services throughout the continuum of care from surgery, chemo, radiation, transitional care and follow-up.
- Improve quality of care and enhance quality of life.
- Establish lines of communication with physicians and patients.
- Make available a network of resources on where to get help for illness and treatment.
- Improve pain management.
- Referral to Hospice care in the appropriate time.
- Provide information and reminders on early detection and prevention.
- Provide information on drug therapies.

Contact the Oncology Nurse Manager at 877-977-0159 option #4 for more information.

CONTINUING HEALTH COVERAGE

The circumstances which permit continuation of your group health coverage at group rates are as follows:

1. If the covered employee dies or becomes eligible for Medicare, covered dependents may continue coverage for up to 36 months.
2. If the covered employee terminates employment, the covered employee and covered dependents may continue coverage for up to 18 months.
3. If a divorce occurs, covered dependents who would otherwise lose coverage may continue coverage for up to 36 months.

4. A covered dependent child who becomes ineligible because of age (reaching age 19 or age 29 if a full-time student, 12 credits or more) or marriage may continue coverage for up to 36 months. A child comes off the plan the end of the month of their 19th or 29th birthday. Each fall and spring semester a request for student verification will be sent to the employee from BOP. Failure to complete will result in claim denial as well as termination of dependent coverage. No deduction is taken for the month the child was born.
5. Upon retirement you may continue with the health insurance at the group rate and have the payment deducted from your retirement check.
6. Early retirees will be allowed to continue their group health insurance at group rates until age 65 at which time you may convert to an employer-sponsored medical supplement plan.
7. Disabled employees: twenty-nine (29) months for disabled employees and/or qualified beneficiary.
8. Covered Spouse Who Retires: To remove from the health insurance, a Medicare eligible letter must be sent to Bureau of Personnel along with a Family State Change Form.

BENEFIT PLAN CONTACT INFORMATION

Bureau of Personnel

All benefit related questions.

PMB 0141-1
Bureau of Personnel
500 East Capitol Avenue
Pierre, SD 57501

605.773.3148

Email: bopinfo@state.sd.us

www.bopweb.com

DAKOTACARE

PO Box 7406
Sioux Falls, SD 57117-7406

1.800.831.0785 (in state)

605.334-4000
Fax: 605.336.0270

www.dakotacare.com

MyFlexOnline.com
www.myflexonline.com

DAKOTACARE Access
<http://secure.healthtx.com/stsd.asp>

DAKOTACARE provides State employees with a system of member doctors and other health care providers as well as serves as third party administrator for the Health and Flexible Benefits Plan.

General Health and Flexible Benefits Plan information, including:

- Eligibility questions (for example, if a child is listed as a covered dependent)
- Questions about claims processing, appeals, coordination of benefits or third party liabilities
- Covered expenses and benefit level information
- Deductible and out-of-pocket expense information
- Plan limitations and exclusions
- "Balance" billing information

Health Plan information, including:

- A list of DAKOTACARE medical providers
- A list of participating Chiropractic Associates LTD of South Dakota (CASD) providers
- Additional I.D. cards

MyFlexOnline.com

Access to Dependent Care Spending Account, Medical Expense Spending Account and/or Health Rewards and Wellness Account:
www.myflexonline.com

DAKOTACARE Access

View your EOB Information Online. DAKOTACARE Access allows members secure electronic access to their personal DAKOTACARE-related claim information for health, flex, dental, vision, major injury protection and hospital indemnity plans.
<http://secure.healthx.com/stsd.asp>

Delta Dental

605.224.7345
1.800.627.3961

- Dental Questions
- New Dental ID Cards after July 1, 2009
- To find a participating dentist go to www.deltadentalsd.com
- Under "Looking for a Dentist?" section click "Dentist Search".
- Select "Delta Dental Premier" and enter a city or zip code.
- Preauthorization for a hospital confinement or other health services requiring preauthorization and medical case management
- Prior-authorization for certain prescriptions
- Register for Our Healthy Baby www.ourhealthybaby.com or call 1.888.821.2242

Health Care Medical Technology Inc. (HCMTI)

2301 West Russell Street
Sioux Falls, SD 57105

866.330.9886 or
605.333.9886

Health Management Programs
1.877.977.0159
Email: dbnurse@hcmti.com

www.hcmti.com

- Questions about managed care
- [HCMTI Newsletter](#)
- Health Management Programs
 - Weight
 - Cardiovascular
 - Diabetes
 - Asthma

Oncology

Express Scripts

Customer Service:
Phone: 1.877.212.9529

www.express-scripts.com

Questions about the Prescription Network

Private HealthCare Systems (PHCS)

1.888.865.7427

www.phcs.com

Nationwide Provider Directory

QUICK CLICK MD

Medical help for State employees

Email:
<https://www.hcmti.com/quickclick.aspx>

SOUTH DAKOTA FLEXIBLE BENEFIT PLAN

The state of South Dakota provides all state employees with a tax-saving fringe benefit plan. This plan is an IRS-approved program that allows employees to pay certain benefit premiums on a tax-free basis. This reduces the employee's taxes and increases their take-home pay. If you need additional information or have questions, please see the Director of Human Resources.

The following are the benefit premiums offered:

- * Short Term Disability Income Protection
- * Hospital Income Protection
- * Major Injury Protection
- * Dental Care
- * Vision Care
- * Dependent Day Care Spending Account
- * Medical Expenses Spending Account
- * Cancer Premiums Conversion (American Family Life Assurance)

Plan Year: July 1 to June 30

SHORT TERM DISABILITY INCOME PROTECTION

The state of South Dakota self-insures its Disability Income Protection Plan. This coverage provides you with income if you cannot perform the material and substantial duties of your occupation due to a covered illness or injury. Benefits Begin – expiration of earned sick leave or after 30 calendar days of total disability. The plan will pay a benefit equal to 60 percent of your monthly salary, up to \$2200 per month maximum, for up to 12 months. Monthly salary does not include bonuses, longevity pay or overtime pay, or summer school compensation. Please see your flexible benefit book for more information. Claim forms and submission of claim should be directed to the Bureau of Personnel.

Short Term Disability Income Protection Premiums

	12 PAY PERIODS
COVERAGE	JULY - JUNE
Employee	\$11.40

(New Enrollments: Contributions and coverage will begin after a six-month waiting period.)

HOSPITAL INCOME PROTECTION

The state of South Dakota self-insures its Hospital Income Protection Plan. Like all of the state's self-insured plans, premiums charged for this benefit cover only anticipated claims against the pool of premiums collected. The plan has no administrative charges, state premium taxes or profit margin included in the premium cost. Claims processed by Dakota Care.

The coverage provides income for you and your covered family members who are hospitalized as a result of an illness or injury. The plan pays benefits for up to 365 days, beginning with the first day of a hospital stay. You can receive a benefit of \$125 per day hospitalized. Please see your flexible benefit book for more information.

Hospital Income Protection Premiums

COVERAGE	12 PAY PERIODS
	JULY - JUNE
Employee	\$10.92
Employee/1 Dependent	\$11.26
Employee/2 Dependents	\$19.34
Employee/3 or more Dependents	\$29.94

MAJOR INJURY PROTECTION

The state of South Dakota self-insures its Major Injury Protection Plan. Like all of the state's self-insured plans, premiums charged for this coverage cover only anticipated claims against the pool of premiums collected. The plan has no administrative charges, state premium taxes or profit margin included in the premium cost. Claims processed by Dakota Care.

This coverage supplements medical benefits if you or a covered family member is injured in an accident. The plan pays specific dollar amounts, based on a schedule of benefits, for injuries suffered on or off the job. The benefits are payable for treatment or services required within 90 days of the accident. Please see your flexible benefit book for more information.

Major Injury Protection Premiums

COVERAGE	12 PAY PERIODS
	JULY - JUNE
Employee	\$ 5.98
Employee/1 Dependent	\$ 6.46
Employee/2 Dependents	\$ 9.68
Employee/Family	\$15.14

DENTAL CARE

The state of South Dakota offers dental coverage through Delta Dental. A Base Plan and an Enhanced Plan are offered. Monthly premiums under Delta Dental are made on a pre-tax basis.

- To receive full benefits, you must visit a Delta Dental participating dentist.
- Members will receive a separate dental card.
- Questions? Contact Delta Dental at 605.224.7345 or 1.800.627.3961.

To find a participating dentist go to: www.deltadental.com.

- Under "Looking for a Dentist?" section, click "Dentist Search".
- Select "Delta Dental Premier" and enter a city or zip code.

Base Plan

- The Plan pays a maximum benefit of \$750 per person per Plan Year for Preventive and Basic Services.

Preventive Services	Coverage	Frequency
Oral Examinations	100%	1 per plan year
Bite-Wing X-rays	100%	once per plan year
Panoramic X-rays	100%	once every 5 years
Prophylaxis (cleaning)	100%	1 per plan year
Fluoride Treatments	100%	1 per plan year < 19 years of age
Sealants	100%	once in a lifetime
Space Maintainers	100%	< 16 years of age

Basic Services	Coverage
Restorations (fillings)	80%
Endodontics (root canals)	80%
Periodontics	80%
Extractions	80%
Palliative Treatment (pain relief)	80%

12 PAY PERIODS

COVERAGE

JULY - JUNE

Employee	\$19.60
Employee/1 Dependent	\$29.32
Employee/2 Dependents	\$46.56
Employee/3 or More Dependents	\$55.92

Enhanced Plan

- The Plan pays a maximum benefit of \$1,000 per person per Plan Year for Preventive, Basic and Major Services.

Preventive Services	Coverage	Frequency
Oral Examinations	100%	2 per plan year
Bite-Wing X-rays	100%	once per plan year
Panoramic X-rays	100%	once every 5 years
Prophylaxis (cleaning)	100%	2 per plan year
Fluoride Treatments	100%	2 per plan year < 19 years of age
Sealants	100%	once in a lifetime
Space Maintainers	100%	< 16 years of age

Basic Services	Coverage
Restorations (fillings)	80%
Endodontics (root canals)	80%
Periodontics	80%
Extractions	80%
Palliative Treatment (pain relief)	80%

Major Services	Coverage
Crowns	50%
Fixed Bridges	50%
Dentures (full and partial)	50%
Onlays	50%
Implants	50%

Orthodontic Services	Coverage	
Orthodontics	50%	Lifetime maximum of \$1,500 per person

12 PAY PERIODS

COVERAGE

JULY - JUNE

Employee	\$31.50
Employee/1 Dependent	\$47.40
Employee/2 Dependents	\$62.60
Employee/3 or More Dependents	\$90.00

VISION CARE

The state of South Dakota self-insures its Vision Care Plan. That means that the premiums charged for this coverage cover only anticipated vision claims against the pool of premiums collected, just as with the Dental plan. There are no administrative charges, state premium taxes or profit margin included in the premium cost. Claims processed by Dakota Care.

This coverage helps you pay eye care expenses for yourself and your eligible family members. Under the schedule of payments, the plan pays 100 percent of the first \$75 of incurred vision costs and 60 percent of the next \$350 of Usual, Customary and Reasonable (UCR) charges with a maximum plan year benefit of \$285 per employee or enrolled eligible family member. There is no lifetime maximum benefit. You can use the eye doctor of your choice. Please see your flexible benefit book for more information.

Vision Care Premiums

12 PAY PERIODS

COVERAGE

JULY - JUNE

Employee	\$12.14
Employee/1 Dependent	\$15.62
Employee/2 Dependents	\$21.44
Employee/3 or more Dependents	\$29.70

DEPENDENT DAY CARE SPENDING ACCOUNT

By "depositing" pre-tax dollars into this account, you will be able to pay for childcare or mentally or physically disabled dependent expenses in a way that offers you significant tax advantages. The account has no minimum, but the maximum in most cases is \$5000. Employees have a 2 ½ month grace period, September 15, to spend or incur claims related to their account. You have one year after the end of the plan year (June 30) to submit claims. Claims processed by Dakota Care. Please see your flexible benefit book for more information. Visit www.myflexonline.com or call 1-800-831-0785 for more information regarding your account.

MARRIED
FILING SEPARATELY
Maximum \$2,500

SINGLE
HEAD OF HOUSEHOLD
Maximum \$5,000

MARRIED
FILING JOINTLY
Maximum \$5,000

If you terminate employment or go on unpaid leave, this reimbursement account continues until the plan year ends or the account balance is zero.

MEDICAL EXPENSE SPENDING ACCOUNT

By "depositing" pre-tax dollars into this account, you will be able to pay for medicines and drugs purchased without a physician's prescription, out-of-pocket medical, dental and vision expenses which are not covered by your other insurance plans. The account has no minimum, but the maximum annual contribution is \$5,000. Employees have a 2 ½ month grace period, September 15, to spend or incur claims related to their account. You have one year after the end of the plan year (June 30) to submit claims. Claims processed by Dakota Care. Please see your flexible benefit book for more information. Visit www.myflexonline.com or call 1-800-831-0785 for more information regarding your account.

AFLAC (AMERICAN FAMILY LIFE ASSURANCE COMPAY (SUPPLEMENTAL PRODUCTS) (www.aflac.com/us/en/individuals/ProductAndServices.aspx)

Various supplemental insurance products are offered by AFLAC. These products are voluntary benefits, and the employee is responsible for the premiums. Depending on the product, the premiums will either be pre-tax or post-tax. Below are benefits being offered.

- Accident/Disability (Pretax/After Tax)
- Cancer/Specified-Disease (Pretax)
- Dental (Pretax)
- Hospital Confinement Indemnity (Pretax)
- Hospital Confinement Sickness Indemnity (Pretax)
- Hospital Intensive Care (Pretax)
- Life (After Tax)
- Long-Term Care (After Tax)
- Short-Term Disability (After Tax)
- Specified Health Event (Pretax)
- Vision (Pretax)

If you would like additional information, contact the Human Resources Director. Arrangements will then be made for an AFLAC representative to contact you to explain the policies and cost of coverages.

PHARMACY NETWORK

Participants in any of the state health plans are eligible for the prescription drug program (offered through Dakota Care and ESI). To view or receive a list of pharmacies that are participating in our network go to www.express-scripts.com or call 1-877-212-9529. When going to a pharmacy provider you must show your Dakota Care ID Card in order to receive the discounts available for claims to be paid properly. If you go to a non-participating pharmacy, you pay the full price for the prescription at the time of purchase. Then you must submit your own claim to ESI for reimbursement. To request claim forms call ESI at 1-877-212-9529 or go to their website at www.express-scripts.com.

Prescriptions expire 365 days from the date that prescription was written. At that time, a new prescription must be ordered by your healthcare provider. Controlled substances are drugs that have the potential for abuse. All prescriptions for controlled substances (example: narcotic pain medications) require a new prescription every 6 months (federal law). Preauthorizations for drugs will expire at a maximum of 365 days from the date the preauthorization is issued. The first fill of a prescription for a drug that is on the maintenance drug list will be filled as a 90 day supply (90 day copay applies).

Allergy serum and oral medications are covered under the ESI Plan. ESI has a specific allergy claim form that can be found online under Forms and Documents at www.BOPweb.com. Charges for administering medications or the office visit are covered under the Health Plan.

Diabetic supplies are covered under the pharmacy component, where most of the supplies are actually obtained. Insulin and needles/syringes (including preloaded syringes) are covered under one copayment if purchased at the same time for up to a 90-day supply. If syringes are purchased separately from the insulin, they are covered under a separate copayment. Diabetic test strips are covered under one copayment for each 30-day supply, maximum of 205 per fill. Lancets are covered under one copayment, maximum of 205 per fill. If purchased at the same time as diabetic test strips, only one copayment applies. Your copayment will vary depending on whether or not you fill your prescription purchasing diabetic supplies that are listed on the formulary.

To view the formulary, log onto www.express-scripts.com.

PRESCRIPTION DRUG COST

Important: Your share of the prescription cost will increase whenever you or your doctor request a brand name and a generic is available. You will pay the generic copayment plus the difference in cost between the generic and the brand name drug when HCMTI does not authorize the brand name drug. The difference in cost could be substantial, and does not apply to your annual out of pocket maximum.

PRESCRIPTION DRUG DEDUCTIBLE

\$300 Deductible and \$1000 Deductible

Fifty dollars (\$50) per person annual deductible will be on prescription drug coverage. Before prescription drug benefits are paid, each person must satisfy the \$50 deductible.

Medication	Cost
Generic-Tier One	\$9.00/prescription for up to 30-day supply (or the U&C cost of the drug, whichever is less) OR \$17.00/prescription for 31 to 90 day supply
Brand-Tier Two	\$25.00/prescription for up to 30 day supply OR \$40.00/prescription for 31 to 90 day supply
Brand-Tier Three	\$40.00/prescription for up to 30 day supply for drugs not on formulary* OR \$60.00/prescription for 31-90 day supply for drugs not listed on formulary*

**Certain drugs are not covered by your prescription drug plan.*

Since this benefit is administered separately from other health benefits, none of these costs apply to your deductible or out-of-pocket maximum, if you have the \$300 Deductible or \$1000 Deductible.

\$2000 Deductible

The prescription drug deductible is included in the plan deductible. Once the plan deductible is met, you pay 25% of the prescription drug costs, up the plan's out-of-pocket limit.

Contact ESI (Mail Service Prescription Program) to fill or refill up to a 90-day supply of maintenance drugs. Call 1-877-212-9529 or visit their website at www.express-scripts.com.

To protect against excessive prescription drug costs, your maximum annual cost for covered medications is \$800 per person and \$2000 for a family of three or more.

If you have any questions, please call ESI at 1-877-212-9529.

DRUGS REQUIRING PREAUTHORIZATION

Certain maintenance drugs and the following categories of drugs require preauthorization. That means your physician must call ESI at 1-877-212-9529 for preauthorization.

Drugs requiring preauthorization include:

- Anabolic Steroids
- Anemia Treatments such as Epogen or Procrit
- Oral Antifungals such as Sporanox or Lamisil (required for treatment for an identified underlying disease)
- Dermatological topicals such as Renova or Retin A
- Diabetic ulcer agents such as Regranex
- Drugs for Gaucher's Disease such as Cerezyme or Serostim
- Growth Hormones
- Selected Interferons such as Rebetrone or Intron A
- Drugs for Multiple Sclerosis such as Betaseron or Avonex
- Anti-obesity preparations (unless required for treatment of a condition caused by or related to morbid obesity)*

PRESCRIPTION MAIL SERVICE PROGRAM

ESI administers a mail service prescription program for state employees. This mail service addresses long-term prescription needs. Examples: prescriptions for blood pressure, asthma, diabetes. To start this service you will need to obtain a new prescription form from your physician and mail it along with your mail service order form. If you do not have a mail service order form, please contact ESI at 1-877-212-9529 or visit their website at www.express-scripts.com. Your prescription should arrive within 5-7 business days of when your order is received by ESI.

CHIROPRACTIC ASSOCIATION OF SOUTH DAKOTA (CASD)

The CASD is available to all health plan participants, at the cost of \$20 per visit. This copayment covers all necessary services received. The \$20 copayment does not apply to the employee's deductible or out-of-pocket maximum. When going to a provider you need to identify yourself as a State Employee Health Plan Participant. Please refer to directory for the list of providers in the CASD. CASD participating provider claims are submitted directly to CASD by the provider. Non-CASD chiropractic claims are submitted directly to Philadelphia American Life by the employee.

DURABLE MEDICAL EQUIPMENT

The State of South Dakota also has contracted with two companies to provide durable medical equipment to employees and their family members: MERSCO Medical, Inc. and PSI, Health Care, Inc. The usual, reasonable and customary charge for prescribed items will be discounted when you rent or purchase equipment from either of these companies. The adjustment will appear on your Explanation of Benefits when your claim is processed by Philadelphia American Life.

Durable medical equipment includes items such as: hospital beds, iron lungs, apnea monitors, oxygen tents, hydraulic lifts, ventilators, and wheelchairs. See your Provider Directory for company locations and numbers to call for information.

LIFE INSURANCE COVERAGE - South Dakota Public Employee Benefit Program (www.bopweb.com)

Basic Life Coverage -- All permanent full-time/part-time employees will automatically have a \$25,000 life insurance policy as long as they are employed at the SDSBVI. Coverage goes into effect one month and one day after your first day of work.

Converting Your Group Life Coverage - Employees leaving state employment can remain with the group life plan at existing group premium rates, within the following parameters:

- * Early retirees are able to continue coverage until the end of the month they reach age 70 at which time coverage will cease.
- * Employees terminating (other than retirement) will receive coverage at group rates for 18 months from when employment ended. Coverage will cease once the 18 months are up.

DEPENDENT LIFE INSURANCE

This is an optional plan available to all full-time/part-time employees at the SDSBVI. Spouses and/or children will have \$10,000 coverage (14 days to 19 years of age and students 23 years of age if a full-time student). Once leaving state employment, coverage will cease after 18 months. In order to receive this coverage, you must enroll in the Employee Supplemental Group Life Insurance through the state. If you would like additional information, contact the Director of Human Resources.

SUPPLEMENTAL GROUP LIFE INSURANCE PLAN AND LONG TERM CARE COVERAGE

Supplemental Group Life Insurance may be purchased by Board of Regent employees who want to add to their existing life plan. It is additional coverage and must be paid by the employee.

Who is Eligible: All permanent employees who work at least 20 hours a week at least 6 months of the year and have a permanent job classification. When both husband and wife work for the state as permanent full-time employees, both are eligible for employee insurance.

When You Are Eligible: Within 30 days of the day you begin work.

How to Join the Plan: New employees enroll during the new hire enrollment period, otherwise through the annual benefit enrollment period scheduled in the spring of each year.

No Medical Examination If You Enroll Promptly: You do not need to take a medical examination if you enroll within 30 days of your hire date. However, if you do not enroll during that period, it is required that you provide proof of insurability. Likewise, if you do not enroll for dependent insurance.

When Your Insurance Becomes Effective: By enrolling during your eligibility period, you will become insured for employee insurance on the warrant date that reflects your first deduction if you are then actively at work; otherwise, on the day you return to active work. The dependent insurance, if you have dependents and have them enrolled for that insurance, will become effective on the day you become insured for the employee insurance.

When You Leave State Employment: Employees that leave state employment may continue their supplement coverage until:

- 1) 18 months from date their full-time benefits end;
- 2) the last day of the month in which they turn age 70.

You may not enroll for dependent insurance without also enrolling for employee insurance. If you become insured for dependent insurance, all of your eligible dependents will be included.

If you have no dependents on the day your employee insurance becomes effective, you may enroll for dependent insurance within 30 days of the date you acquire a dependent, and your dependent insurance will become effective on the date the person becomes your dependent or the date you enroll for dependent insurance, whichever is later.

Life Coverage -- Employee

The amount of coverage you may purchase ranges from 2 to 5 times your salary. If, for example, your salary is \$15,000 per year, you could purchase \$30,000, \$45,000, \$60,000 or \$75,000 in life insurance by selecting one of the options.

- Option 1 - 2 times your basic annual salary
(up to a maximum of \$400,000)
- Option 2 - 3 times your basic annual salary
(up to a maximum of \$400,000)
- Option 3 - 4 times your basic annual salary
(up to a maximum of \$400,000)
- Option 4 - 5 times your basic annual salary
(up to a maximum of \$400,000)

In calculating the amount of life insurance, your salary will be adjusted to the next higher multiple of \$1,000 if it's not an even multiple of \$1,000. Example: A salary of \$9,999 will be adjusted to \$10,000. In this example, if Option 1 were selected, the amount of your life insurance would be \$20,000 (\$10,000 x 2). The cost of your coverage is determined by the amount of insurance you select and your age. The table below shows the cost per month for each \$1,000 of coverage. The amounts have been rounded to the nearest cent. Maximum benefit is \$400,000.

<u>Employee Coverage</u> <u>Age Group</u>	<u>Contribution Rate Per \$1,000 of Coverage</u>
Younger than 30	.04 cents
30 to 34	.04 cents
35 to 39	.06 cents
40 to 44	.09 cents
45 to 49	.11 cents
50 to 54	.20 cents
55 to 59	.22 cents
60 to 64	.39 cents
65 to 69	.92 cents
70 +	\$1.84

LONG TERM CARE INSURANCE (LTC) – UNUM PROVIDENT (Policy 295435)

Active employees who carry the State's Group Supplemental Life Plan will automatically receive a Basic Long-Term-Care (LTC) benefit, paid for by current premiums. UnumProvident insures this benefit. The Basic benefit provides \$1,500 per month if a member is unable to work due to the loss of two or more Activities of Daily Living (ADLs) and is confined to a nursing home. Partial benefits are provided if a member resides in an Assisted Living Center or receives professional help in the home. The maximum amount for this benefit will be \$36,000 (2 year duration at \$1,500 per month).

Active holders of the State's Group Supplemental Life coverage will be given the option to buy up to higher levels of LTC at group rates. Rates are based on what age you are when you purchase LTC. Active employees will have Guarantee Issue during the enrollment period but some exceptions apply. An employee's immediate and extended family members can apply for LTC through the medical underwriting approval process at negotiated group rates. LTC is portable. Questions, please contact UnumProvident at 1-800-227-4165 or visit their website at w3.unumprovident.com/enroll/southdakota.

THREE-YEAR TERM LIFE INSURANCE - Reliastar\ING Life Insurance (www.ing-usa.com)

The Three-Year Term Life Insurance Program is an optional plan available to employees of the Regents of Education and the SDSBVI. The Life Insurance Program is designed for all permanent employees. As an eligible employee you are guaranteed an amount of term life insurance protection regardless of health or age if you apply within 30 days from the date of employment. The following schedule illustrates the specific amounts of guaranteed coverage you are eligible for:

<u>Age</u>	<u>Guaranteed Issue Amount</u>
Under 60	\$10,000, \$20,000 or \$30,000
60-64	\$ 6,500, \$13,000 or \$19,500
65-69	\$ 4,500, \$ 9,000 or \$13,500
70-74	\$ 3,000, \$ 6,000 or \$ 9,000

When first enrolling, any amount you request over the maximum guaranteed issue amount (for your age) requires a medical examination or other insurability is required.

Once you are enrolled in the Plan, you may purchase additional coverage during the Plan's annual renewal period: \$5,000 or \$10,000 annually (if under age 60) up to a total of \$80,000. Any coverage over \$30,000 does require a medical examination. Should you decline this option, you may apply for additional coverage in future years but your guaranteed acceptance privilege lapses. You may also choose to purchase additional amounts of coverage up to \$25,000. This additional coverage is subject to approval by the insurance company.

The basic plan is three-year term insurance, renewable for successive three-year term periods, providing coverage to age 75 or termination of payroll deduction, whichever is earlier. The premium rates go with you when you leave your current employer or move into retirement. Only a nominal direct-billing fee is added. You also have the option to convert your policy to a permanent whole-life insurance plan offered by NWNL.

Your spouse is eligible to apply for coverage up to \$95,000. The guaranteed acceptance feature is not available to spouses. All spouse coverage is subject to approval by NWNL. Spouse coverage may not exceed employee's coverage.

One rate covers all your children and their coverage acceptance is guaranteed if you apply during your enrollment period or within 30 days of your child's birth. Older children through age 24 are also included even if they are married or in military service.

WHOLE LIFE INSURANCE - New York Life Insurance (www.newyorklife.com)

The Whole Life Insurance Program is an optional plan available to all permanent South Dakota state employees. Optional coverage for your spouse and/or children is also available. Depending on the amount of protection you choose, premium payments can range from \$10 per month to \$100 per month. Monthly premiums are paid automatically by payroll deduction. When you retire or leave state government, the plan goes with you. The plan is issued for employees and spouses to age 70, and children age 0 to 25. Employee's spouse and/or children are guaranteed a maximum of a \$25,000 policy. (Once a year open enrollment.) [This plan is not a 403B.]

EMPLOYER-PAID GROUP INSURANCE FOR EMPLOYEES ON LEAVE WITHOUT PAY - (This is the South Dakota Board of Regents Policy on Employer-Paid Group Insurance for employees on leave without pay or temporary reduction to less than full-time employment.)

Employees granted leave without pay or a temporary reduction to less than full-time employment for one month or more will continue to have the employee's share of the group health/life/ADD (Accidental Death and Dismemberment) paid for by the Regents/institution for up to a total of three (3) months per leave without pay or temporary reduction. An employee may be granted a leave or temporary reduction for group health/life/ADD premiums if they desire to remain covered by group policy.

Nine, ten or eleven month employees who have contracts and/or letters of intent and/or letters of notification of employment for the following year will continue to have their share of the premium paid for by the Regents/institution for the non-appointment period. Insurance premiums will not be paid by the employer for leave without pay or temporary reductions in time during the appointment period for such employees if such payment combined with the non-appointment months would exceed three (3) months.

Note: Only those leave without pay periods or temporary reductions to less than part-time employment that are one month or more duration are considered under this policy.

WORKER'S COMPENSATION CLAIMS PROCEDURE

As a South Dakota state employee, you are covered by an insurance program that pays medical and disability benefits for work-related injuries and diseases. The Worker's Compensation Program for state employees is administered by the Bureau of Personnel.

Injury Reporting Procedure: If you are injured or contract an occupational disease on the job, you must report it as soon as possible. Report the circumstance of the injury or disease to your **immediate supervisor and/or the Director of Human Resources for filing the electronic First Report of Injury form, no later than three (3) business days after the occurrence.** Failure to notify your supervisor or the Director of Human Resources may result in denial of your claim. Within seven (7) calendar days after the employer has knowledge of the injury, the electronic First Report of Injury form must be filed within the Bureau of Personnel.

The web link for filing is <https://www.bopweb.com/SiteNavTemplateA.asp?id=850>.

If you fail to report your claim on time, it may be denied. Keep in touch with your human resource office to assure the claim is properly filed and monitored. All claims will be thoroughly investigated by the Bureau of Personnel.

Selection of Medical Practitioner: You have the right to initially select a medical practitioner. Before seeing your practitioner you need to obtain a Workmen's Compensation Work Status Report Form from the Director of Human Resources. These forms are also located in the infirmary, staff lounge and houseparent supervisor's office. This form needs to be completed by the practitioner and then returned to the Director of Human Resources. **If you want to change medical practitioners, you must submit a written request to the Bureau of Personnel for approval.** If your medical practitioner refers you to another practitioner for further treatment, you do not need permission to see that practitioner. **But remember—if another medical practitioner is consulted for a second opinion without referral or the Bureau of Personnel's approval, it will be at your own expense!**

You also need to give prior notification to the State's Managed Care Program for hospitalization or surgery, unless it is an emergency.

If you have already seen a medical practitioner about your injury or disease, be sure that your employer includes the medical practitioner's full name and complete address on the Employer's First Report of Injury form. If the medical practitioner's name and address are not on the Employer's First Report of Injury form, please send that information to the Bureau of Personnel as soon as possible. This same information applies to hospital or other medical practitioners.

Your medical practitioner must submit a report to Dakota Care fourteen (14) days after treatment. A medical bill should be attached to the report for faster processing. You must get prior approval from the Bureau of Personnel to purchase orthopedic devices or physical therapy equipment.

Any medications prescribed by your physician for the work-related injury or disease must be paid for with your prescription card.

Filing for Disability Benefits: You cannot be paid for lost work time unless you are incapacitated for seven (7) consecutive days. Make sure the person who files worker's compensation reports in your department notifies the Bureau of Personnel when you have been off work beyond this period. No compensation for lost time payments can be made until the Bureau of Personnel has received such notice.

If you are placed on Temporary Total Disability (according to SDCL 62-4-3), it is your responsibility to:

1. Provide the Bureau of Personnel with a medical practitioner's slip indicating the period of time you will be unable to work.
2. Notify the Bureau of Personnel if your medical practitioner releases you to return to work or if you intend to resign or change employers.

If you fail to furnish this information, your benefits could be delayed or suspended. Legal action is possible in cases of fraudulent claims, for example, if a person returns to work while receiving disability benefits.

An agreement regarding compensation and a voucher payable to the injured employee will be mailed to your employer's office which filed the Employer's First Report of Injury. You must sign the agreement and the voucher and return them to the Bureau of Personnel.

Every effort will be made to allow you to return to work as soon as possible. At a minimum, you should maintain weekly contact with your supervisor or Director of Human Resources.

Use of Sick Leave/Vacation Pay as Supplement: If your worker's compensation benefits are not equal to your salary, state law (SDCL 3-6-8.2) says you may use sick leave or vacation pay in an amount necessary to make up the difference between your salary and the worker's compensation benefits.

If you have any questions concerning your claim, please contact the South Dakota BOP Worker's Compensation Program (605-773-3148)

UNEMPLOYMENT INSURANCE

Section 61-6-1.6 of the SDCL provides that employees of schools will be denied benefits during a customary vacation period, a day of legal discontinuance or a holiday in addition to the period of time between two successive academic years (i.e. if they were employed at the end of the spring term and if there is reasonable assurance that they will be employed in the same or an equal capacity during the next time).

If an employee is terminated with good cause not attributable to the employer or for misconduct, benefits for unemployment insurance may also be denied. A decision is rendered by the Unemployment Insurance Division upon filing a claim through a Job Service Office.

Termination resulting from a layoff due to lack of work usually results in the receipt of unemployment insurance benefits.

SOUTH DAKOTA RETIREMENT PLAN (401a)

All employees of the South Dakota School for the Blind and Visually Impaired who work twenty (20) hours a week for at least six (6) months of the year must participate in the South Dakota Retirement System. An employee becomes a member on the date of hire. The employee must complete the necessary enrollment forms in the administration office in order to designate a beneficiary. The employee contribution is six percent (6%) of total earnings for the fiscal year and are matched by the Board of Regents. The six percent (6%) employee contributions to the retirement system are not taxable for Federal Income Tax purposes. This tax break went into effect on July 1, 1984. The contributions are subject to Social Security tax. Interest on accumulated contributions are credited monthly. Please check your S.D.R.S. pamphlet.

SDRS Phone: 605-773-3731 or 1-888-605-SDRS

SDRS Website: www.sdrs.sd.gov

Withdrawal of Contributions:

➤ **Less Than Three Years of Credited Service**

Option 1: Take refund -- 100 percent of employee, 75 percent of employer contributions, plus interest. As of July 1998, interest is credited monthly instead of annually. By taking this refund one forfeits all SDRS benefits. Employees can roll their refund into an IRA or another employer retirement plan, or keep their refund for personal use, pay income tax and 10 percent early withdrawal penalty if under age 59 1/2.

Option 2: Leave contribution with SDRS up to 10 years. Contributions continue to draw interest.

➤ **Three or More Years of Credited Service (vested)**

Option 1: Take refund: 100 percent of employee, 100 percent of employer contributions, plus interest. As of July 1998, interest is credited monthly instead of annually. By taking this refund one forfeits all SDRS benefits. Employees can roll their refund into an IRA or another employer retirement plan, or keep the refund for personal use, pay income tax and 10 percent early withdrawal penalty if under age 59 1/2.

Option 2: Leave contributions with SDRS until retirement. Value of benefits grows by 3.1 percent each year; future benefits improvements will also increase value. At retirement, employee will receive benefits that will continue for life.

Effective July 1998, new retirees will receive on the next July 1 a prorated share of the cost of living increase based on the numbers of months he or she has received a benefit, and a full cost of living increase each July 1 thereafter.

Example: A member who receives his or her first benefit payment in August would receive 11/12 of the cost of living increase for the current year.

SDRS members all vest after three (3) years of credited service.

When You Can Retire – Before retiring contact the South Dakota Retirement System at 605-773-3731 or 1-888-605-SDRS.

Normal Retirement: Normal retirement age is 65 if you have at least three (3) years of credited service under the South Dakota Retirement System. Your normal retirement date is the first day of the month of your 65th birthday.

Regular Early Retirement: If you have completed at least three (3) years of credited service, you may retire as early as age 55 and receive monthly lifetime benefits from SDRS. You may begin receiving retirement payments right away or you can wait and begin receiving payments at a later date. If you decide to begin receiving your payments before age 65, your payments will be reduced because it is expected that they will be stretched out over a longer period of time. The amount of the reduction depends upon your age and years of credited service.

Special Early Retirement: You can retire as early as age 55 and receive full monthly lifetime benefits immediately, with no reduction in monthly payments, as long as you meet the “Rule of 85”. The “Rule of 85” is when your age and your years of credited service total 85.

[HB1032] Compensation in the last quarter cannot exceed 115 percent of any previous quarter and average compensation in last four (4) quarters cannot exceed 110 percent of any previous quarter.

Beginning July 1, 2005, compensation in last quarter or average compensation in last four (4) quarters cannot exceed 105 percent of any previous quarter.

Special Pay Plan (401a) [House Bill 1033]

This plan is mandatory for all permanent employees who terminate in the calendar month prior to their 55th birthday and who will receive termination pay above \$600, maximum deposit amount \$41,000. The plan only accepts termination payments (annual leave, sick leave, contract buyouts, retirement incentives and all other lump sum payments) at the end of a permanent employee’s career. These payments are exempt for FICA, income tax, and retirement. Each member will self direct the investment of his or her funds within the plan. Participants are immediately vested. Members can withdraw funds as soon as administratively possible. Twenty-four hour Special Pay Plan service is available through Supplemental Retirement Plan (SRP) website (www.SRP457.com) or 1-800-959-4457.

Protection For Your Survivors:

If you die while still employed -- A family benefit and spouse benefit are paid monthly if you die while participating in SDRS. The family benefit is payable when children under the age of 18 are in the home, and the spouse benefit becomes effective when your spouse reaches the age of 65. Calculation of family benefits will be based on the final average compensation.

If you die after retirement – SDRS also pays survivor benefits to your spouse after you have retired. This benefit is equal to 60 percent of the benefit being paid to you at the time of your death and will continue for your spouse’s lifetime. If both you and your spouse die before you have received all contributions, your named beneficiary or estate will receive the balance. To qualify for death benefit, your spouse must have been married to you prior to your retirement date and for at least 12 months before your death.

Buying Additional Service: Eligible members can buy additional years of credited service for years of public service when they could not participate. Your cost to purchase credit service depends upon your age at the time of your purchase. The cost is an actuarially determined percentage of your current salary. Below is the percentage table.

Age at Purchase	% of Combined Contributions*	% of Pay
40 and Younger	100%	12.0%
41	110%	13.2%
42	120%	14.4%
43	130%	15.6%
44	140%	16.8%
45	150%	18.0%
46	160%	19.2%
47	170%	20.4%
48	180%	21.6%
49	190%	22.8%
50	200%	24.0%
51	210%	25.2%
52	220%	26.4%
53	230%	27.6%
54	240%	28.8%
55 and Older	250%	30.0%

Purchasing credited service through payroll deduction is tax deferred. Employees can take up to ten (10) years to purchase credited service.

Reinstating Past Credited Service: If you withdraw your contributions from a previous employer, you may be entitled to reinstate your past service. To do so you must be rehired on a permanent basis and repay any contributions you received, plus interest. The repayment must be made no later than two years after your hire date. This must be made in a lump sum payment.

Retired Employees Who Are Re-Employed By An SDRS Employer:

1. Change in the COLA – The annual cost-of-living adjustment (COLA) of 3.1 percent will not be paid on a member's retirement benefit while the member is re-employed by an SDRS employer.
2. New Member Status – Rehired members will participate in SDRS as new members, which means they must work an additional three years to become vested again and qualify for add-on retirement benefits.
3. Add-On Benefit – When members retire for the second time, the add-on retirement benefit will be based on the period of re-employment only.

Disability Before Age 65: If you cannot work because of a disability that occurs before age 65 and is expected to last one year or longer, you may receive a monthly benefit from SDRS. This benefit is payable until age 65, when retirement benefits begin. While you are drawing disability benefits, you continue to earn service credit toward your retirement as if you were continuously employed. You are eligible for disability benefits after three (3) years of credit service. If you are accidentally disabled while performing the usual duties of your job, you are immediately eligible for benefits. You must be a contributing member at the time you become disabled. If you become disabled, the formula for calculation will be based on the final average compensation.

Spouse Option - Optional Survivor Coverage: When a member dies, his/her family is entitled to a survivor benefit (Family Benefits) from SDRS provided there are children under age 18. When the youngest child reaches age 18, however, this benefit ends, and the surviving spouse will not collect until age 65. The spouse option coverage can bridge the gap between the end of family benefits and the beginning of spouse benefits. Spouse option provides an annual benefit equal to 40 percent of a members highest average salary in the last three years of employment. The cost of coverage is only 1.2 percent of salary. Members pay via monthly payroll deductions. A member may end their participation in the program at any time. Contributions are not refunded even if you withdraw from the program. Not everyone is eligible for this coverage. A new member of SDRS may sign up within the first 365 days of employment, while others participate by enrolling within: 90 days after reaching age 35, or 90 days after the first anniversary of a marriage. Please see the Director of Human Resources for more information.

SOUTH DAKOTA RETIREMENT SYSTEM SUPPLEMENTAL RETIREMENT PLAN (SRP) [457 PLAN]

SRP is designed to simplify the task of personal savings, give you alternatives for investing your savings that you may never have had before, and reduce your income taxes, as well. You can direct your contributions into a single investment alternative or into many. Contributions are payroll deducted and are pre-taxed. A minimum of \$25 a month can be put into one of these accounts. Maximum amount to contribute per calendar year is \$15,500. You are not taxed until you withdraw your contributions after retirement. SRP is a part of the retirement plan, and benefits normally begin at the end of your working career. You can choose one of the following methods of withdrawing your savings:

1. A lump-sum or partial lump-sum payment
2. A lifetime annuity - a guaranteed dollar amount for life.
3. Equal periodic payments
 - a) A percentage of the total fund paid out over a fixed period
 - b) A monthly fixed dollar amount paid out until the funds are depleted.

You may also withdraw your SRP in three other instances as follows:

1. If you leave your job and are no longer eligible to contribute. (You can also leave your contribution in the plan until you retire.)
2. If you die before you begin benefits.
3. If you experience an unforeseeable emergency (severe financial hardships caused by events beyond your control).

If you are interested in signing up or need more information, contact the Director of Human Resources or call or write:

SDRS Supplemental Retirement Plan
 207 East Capitol
 Pierre, SD 57501
 Telephone: 605-224-2230 / 1-800-959-4457

SAVINGS BONDS - SERIES EE

The savings bonds program is available to all permanent South Dakota School for the Blind and Visually Impaired employees through payroll deduction. Bonds can be purchased for employee, spouse and/or children at the following rates:

<u>Denomination</u>	<u>Price</u>
\$ 50	\$25.00
\$ 75	\$37.50
\$ 100	\$50.00
\$ 200	\$100.00
\$ 500	\$250.00
\$ 1,000	\$500.00
\$ 5,000	\$2,500.00
\$10,000	\$5,000.00

See the Director of Human Resources for the appropriate enrollment form to be completed.

BOR COLLEGE ACCESS 529 PLAN (PIMCO)

BOR employees can take part in a College Access 529 Plan as a payroll deduction. To enroll, arrangements need to be made through a PIMCO agent. Contact the Director of Human Resources for more information.