ANNUAL ENROLLMENT DATES: MAY 6-20, 2020

FY21 Retiree/COBRA Decision Guide

FY21 (July 1, 2020 - June 30, 2021)

SOUTH DAKOTA
state employee benefits program
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FY21 Retiree/COBRA Decision Guide

South Dakota State Employee Benefits Program

Enroll in Benefits: May 6-20, 2020

Annual Enrollment is the only time during the plan year you can make changes to your health or flexible benefits without a valid family status change.

If you want to make changes, please return the form by May 20, 2020.

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 and/or vision coverage at any time. However, you will not be able to re-enroll in the plan(s) in the future.

No action is necessary if you do not wish to make changes. If you do not submit an Enrollment form, your health, dental and/or vision plan(s) will remain the same, as long as you continue to meet the eligibility requirements of the plan in which you are enrolled.

Personal information changes (addresses, telephone numbers) can be made at any time by calling 605.773.6027 or emailing benefitswebsite@state.sd.us.

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What's new in FY21

- Delta Dental has introduced a new program called Health Through Oral Wellness. With this program, your accredited dentist can conduct a Risk Assessment for you. If you meet the criteria for enhanced risk for periodontal disease, you will be eligible for additional benefits. Please see page 10 for more details.

Important Info

- You must visit a DAKOTACARE network or Sanford provider to receive the highest level of benefits.
- Family status change forms are due to the Bureau of Human Resources within 30 days following a qualifying event, such as birth, marriage, adoption, or divorce.
- Certain pharmacy and medical services must be pre-authorized. To view the pre-authorization listing, visit https://bhr.sd.gov/benefits/active/forms-documents/index.html under "Other."
- Eligible preventive care services are covered even before you meet your annual deductible. To view eligible preventive care services, visit https://bhr.sd.gov/benefits/active/health-plans/preventative-care/.
- Out-of-Network provider means:
    - A DAKOTACARE network or Sanford provider did not provide care;
    - You did not receive approval from Health Management Partners for a referral to an out-of-network provider; or
    - You failed to obtain pre-authorization when necessary.
    - Expenses not covered by the Health Plan do NOT apply to the deductible or the out-of-pocket maximum.
- If a member elects to receive out-of-network services without an approved in-network referral (a Health Management Partners pre-authorization that establishes medical necessity) but is only approved for out-of-network benefit indicating the service could have been provided within the State's preferred provider network, the member will pay a penalty of 30% of the billed charges and this penalty does not apply to the member's annual Out-of-Pocket Maximum.

Compliance Documents

Numerous compliance documents are always available for your review at https://bhr.sd.gov/benefits/active/forms-documents/compliance-documents/index.html.

Low Deductible Health Plan

($1,500 single coverage / $3,750 family coverage)

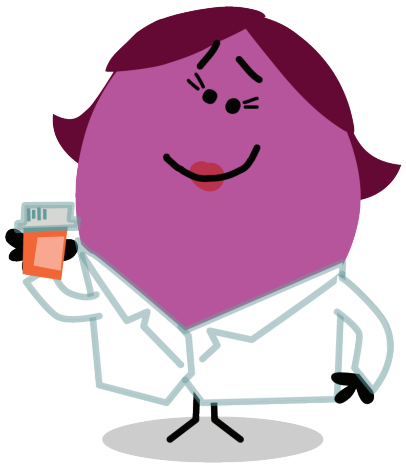
- The Low Deductible Health Plan deductible is $1,500 for single coverage or $3,750 for a family of three or more.
- The in-network, out-of-pocket maximum for this plan is $4,400 per person or $9,375 for a family of three or more.
- The prescription deductible is $150.
- The annual prescription out-of-pocket maximum for the Low Deductible Health Plan is $1,500 per person or $3,750 for a family of three or more.
- See comparison chart on page 6.

How Prescription Drug Coverage Works

There is a separate $150 deductible (per person, per plan year) for prescription drugs on the Low Deductible Health Plan. Copayments apply after you meet the deductible. If the price is less than the listed copayment, you will pay the lesser of the two amounts.

PRESCRIPTION DRUG COVERAGE UNDER THE LOW DEDUCTIBLE HEALTH PLAN		
*Tiered Prescription Drug Coverage	Up to 30 Day Supply Copayment	60-90 Day Supply Copayment
Tier 1 - Generic	$15	$37.50
Tier 2 - Brand Preferred	$55	$137.50
Tier 3 - Brand Non-Preferred	$75	$187.50
Tier 4 - Specialty Preferred	$85	n/a
Tier 5 - Specialty Non-Preferred	$110	n/a

*To determine your prescription's category, please visit your local pharmacy or call CVS at 1.866.443.1185.



High Deductible Health Plan

($2,200 single coverage / $4,400 family coverage)

High Deductible Health Plan with Health Savings Account (HSA)

- All eligible health plan expenses, including prescription drugs, apply toward the deductible.
- There is a $2,200 deductible for single coverage, and a $4,400 deductible for family coverage (for a family of two or more). The family deductible is a combined deductible.
- If you have family coverage, you will pay $4,400 before the plan pays for anything (other than eligible preventive services).
- The High Deductible Health Plan is paired with a Health Savings Account (HSA) to allow you to pay for covered medical expenses.
- An HSA is compatible only with the High Deductible Health Plan.
- The in-network, out-of-pocket maximum for this plan is $5,300 per person or $10,275 for a family of two or more.

How Prescription Drug Coverage Works

PRESCRIPTION DRUG COVERAGE UNDER THE HIGH 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.
Pharmacy charges are applied to deductible: $2,200 single coverage or $4,400 family coverage per family of two or more.
After the deductible has been met, the member pays 25% coinsurance for covered generic and brand preferred prescription charges. The member pays 37.5% coinsurance for covered brand non-preferred prescription charges. Coinsurance continues throughout the plan year until the out-of-pocket maximum is met.

PREVENTIVE THERAPY DRUG COVERAGE ON THE HIGH DEDUCTIBLE HEALTH PLAN		
Prescriptions included on the preventive therapy list at https://bhr.sd.gov/benefits/active/forms-documents/index.html will be available to you at a reduced price even before you meet your deductible.		
*Tiered Prescription Drug Coverage	Up to 30 Day Supply Copayment	60-90 Day Supply Copayment
Tier 1 - Generic	$0	$0
Tier 2 - Brand Preferred	$55	$137.50
Tier 3 - Brand Non-Preferred	$75	$187.50
Tier 4 - Specialty Preferred	$85	n/a
Tier 5 - Specialty Non-Preferred	$110	n/a

*To determine your prescription's category, please visit your local pharmacy or call CVS at 1.866.443.1185.

- Only prescriptions on the preventive therapy list will be available to members of the High Deductible Health Plan at no cost (generic drugs) or at a maximum of $110 for a 30-day supply. This is to help you continue to take preventive maintenance drugs before satisfying the deductible. To see a complete list of prescriptions covered by preventive therapy, go to https://bhr.sd.gov/benefits/active/forms-documents/index.html.

FY21 Health Plan Comparisons

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 FY21				
Plan Details	Low Deductible Health Plan		High Deductible Health Plan - HSA Compatible	
	Network Provider[1]	Out-of-Network Provider	Network Provider[1]	Out-of-Network Provider
Eligible Preventive Services[2]	Covered at 100%	Not covered[3]	Covered at 100%	Not covered[3]
Plan Year Deductible	• $1,500 per person • $3,750 per family of three or more [4]	• $3,000 per person • $7,500 per family of three or more	• $2,200 single coverage • $4,400 family coverage per family of two or more	• $4,400 single coverage • $8,800 family coverage per family of two or more
			If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	
Copayment	• Emergency Room: $250 • Does not count toward your deductible but does count toward your out-of-pocket maximum.		N/A	
Coinsurance	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%
Plan Year Out-of-Pocket Maximum (includes deductible)	• $4,400 per person • $9,375 per family of three or more	• $8,300 per person • $18,250 per family of three or more	• $5,300 single coverage or any one family member • $10,275 family coverage per family of two or more	• $9,200 single coverage or any one family member • $19,150 family coverage per family of two or more
Prescription Drugs				
Deductible	$150 per person	$150 per person	• Included in Plan Year Deductible • Preventive therapy medications may be available at a lower cost. You can find the list at https://bhr.sd.gov/benefits/active/forms-documents/index.html	
Pharmacy Out-of-Pocket Maximum	• $1,500 per person • $3,750 per family of three or more		Included in Plan Year Out-of-Pocket Maximum	

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

[2]To view eligible preventive care services, visit https://bhr.sd.gov/benefits/active/health-plans/preventative-care/.

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

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

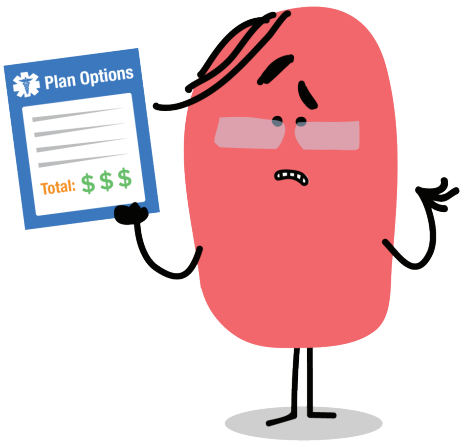
FY21 Health Plan Contributions

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

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

FY21 RETIREE MONTHLY CONTRIBUTION RATES		
Coverage Level	Low Deductible Plan ($1,500)	High Deductible Plan - HSA Compatible ($2,200/$4,400)
Retiree	$2,438.76	$1,170.02
Retiree + Spouse	$5,326.89	$2,184.00
Retiree + Child(ren)	$3,068.33	$1,412.09
Family	$5,956.47	$2,426.05
NOTE: Contributions for retiree and spouse surcharge will increase $60 per person per month if retiree and/or covered spouse use tobacco.		

FY21 COBRA MONTHLY CONTRIBUTION RATES		
Coverage Level	Low Deductible Plan ($1,500)	High Deductible Plan - HSA Compatible ($2,200/$4,400)
Participatant Only	$696.99	$653.31
Participant + Spouse	$1,505.31	$1,410.50
Participant + Child(ren)	$1,070.80	$1,005.81
Family	$1,878.41	$1,762.26
NOTE: Contributions for COBRA participant and spouse surcharge will increase $60 per person per month if COBRA participant and/or covered spouse use tobacco.		



FY21 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.
- The Base and Enhanced Plans pay for services based on a percentage of allowable charges.
- The member is responsible for the deductible, charges that exceed the covered percentage of allowable charges, and any charges over the annual maximum.
- Delta Dental offers a dental network that includes 98% of the dentists in South Dakota.
- You can visit the dentist of your choice but 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 you for the remaining amount.
- Orthodontic cases may be paid over two years based on treatment plan.
- Delta Dental will pay $1,000 for orthodontics in the first year on either plan. In order to receive the additional $1,000 payment in the second year on the Enhanced Plan, the enrollee must continue to be enrolled in the Enhanced Plan.
- To find a participating/network dentist, visit www.deltadentalsd.com and click on 'Find a Dentist.'
- **Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.**

Base Dental Plan Premiums

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

Enhanced Dental Plan Premiums

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

Dental Plan Overview

	Base Plan	**Enhanced Plan**
Annual Maximum	$1,000 per covered person	$2,000 per covered person
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 or Orthodontic Services	no waiting period	no waiting period

Dental Plan Coverage

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

[1] The covered percentage of allowable charges paid after the $25 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 $1,000 for the plan year. MBA maximum is $2,000 per member.

Dental Maximum Bonus Account (MBA)

DELTA DENTAL®

- Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $1,000 for the plan year.
- The MBA maximum is $2,000 per member.
- You must be enrolled in the Enhanced Plan for one plan year before you can earn MBA benefits.
- You, your spouse and dependents will each have their own account. MBA benefits cannot be shared.
- MBA benefits cannot be used for orthodontic claims.
- Your MBA account balance rolls over year-to-year.
- If you move from the Enhanced Plan to the Base Plan, you will lose your account balance.
- You will also lose your account balance if you have a break in coverage.
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Health *through* Oral Wellness

Health through Oral Wellness® is a unique, patient-centered program that adds benefits to a Delta Dental plan based on individual oral health needs. A Delta Dental network dentist trained in Health through Oral Wellness® will conduct a clinical risk assessment during a regular preventive visit. The assessment measures the risk and severity of periodontal disease, and the risk of tooth decay.

If the assessment determines a member is at risk for tooth decay, additional benefits include fluoride treatments, sealants, and oral hygiene instruction. If a member is at risk for periodontal (gum) disease, has periodontal disease or has had periodontal surgery, the member will be eligible for two additional cleanings* and two fluoride treatments.

If a member has any of the following health conditions, they are eligible for additional benefits:

- Diabetes (2 additional cleanings*)
- High-risk cardiac care (2 additional cleanings*)
- Kidney failure or dialysis (2 additional cleanings*)
- Cancer-related treatment - chemotherapy or radiation (2 additional cleanings* and 2 applications of fluoride varnish)
- Suppressed immune system (2 additional cleanings* and 2 applications of fluoride varnish)
- Rheumatoid arthritis (2 additional cleanings*)
- Stroke (2 additional cleanings*)
- Pregnancy (1 additional cleaning* during the time of pregnancy)

* Cleanings can either be a general cleaning (prophylaxis) or a periodontal maintenance cleaning. Periodontal maintenance cleanings are typically covered under the "Endodontics and Periodontics" category, not the "Diagnostic and Preventive Services" category.

Vision Plan

Coverage Level	Monthly Premiums
Participant	$7.22
Participant + Spouse	$14.46
Participant + Child(ren)	$12.24
Participant + Family	$20.20

The Vision Plan is now provided by EyeMed Vision Care, LLC.

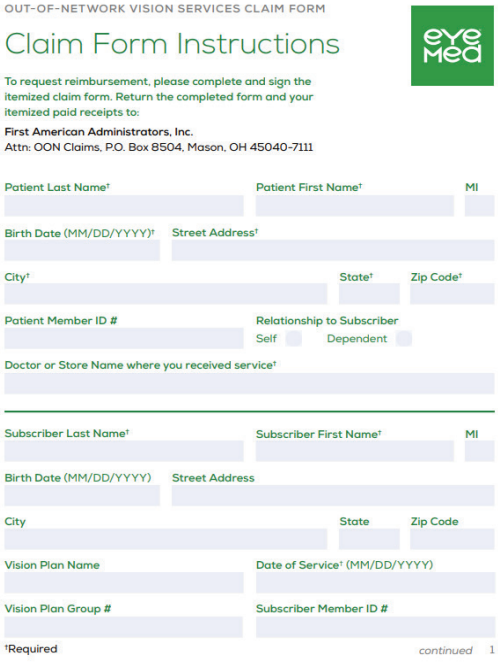
- You cannot add vision coverage during Annual Enrollment. You can only make changes to your current election or cancel your coverage.
- You can see the vision care doctor of your choice, but you may pay the lowest out-of-pocket cost if you visit an in-network provider.
- You can find an in-network provider by visiting https://eyemedvisioncare.com/sosd, clicking on 'Find a Provider,' entering your zip code, and choosing the network, Insight.
- **Call EyeMed at 888.626.6334 to answer any benefit questions and confirm your provider options.**

Submitting an Out-of-Network Claim

If your eye care provider is out-of-network, you can still be reimbursed partially for services received. To do this, you will need to complete the fields located on page 4 of the Out of Network claim form. Your form must be filled out and submitted within 15 months of the date of service.

- No in-network provider within 20 miles of where you live? Complete the Network Adequacy section of out-of-network claim form to be reimbursed as if you visited an in-network provider. If you visit an out-of-network provider for your eye exam because there are no providers within 20 miles of where you live, you will be charged the retail price at point of sale. If you were charged $100 for your exam, EyeMed would reimburse you $90 (in-network copay is $10), if you complete the Network Adequacy part of the out-of-network claim form.

- Visit https://bhr.sd.gov/benefits/active/flexible-benefits/vision-plans/ and click on the Instructions form.
- After viewing the instructions, please click on and view the out-of-network claim form.
- After completing the form, you may upload it or mail it in.



OUT-OF-NETWORK VISION SERVICES CLAIM FORM

Claim Form Instructions

To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts to:

First American Administrators, Inc.
Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Patient Last Name† | Patient First Name† | MI

Birth Date (MM/DD/YYYY)† | Street Address†

City† | State† | Zip Code†

Patient Member ID # | Relationship to Subscriber: Self ☐ Dependent ☐

Doctor or Store Name where you received service†

Subscriber Last Name† | Subscriber First Name† | MI

Birth Date (MM/DD/YYYY) | Street Address

City | State | Zip Code

Vision Plan Name | Date of Service† (MM/DD/YYYY)

Vision Plan Group # | Subscriber Member ID #

†Required

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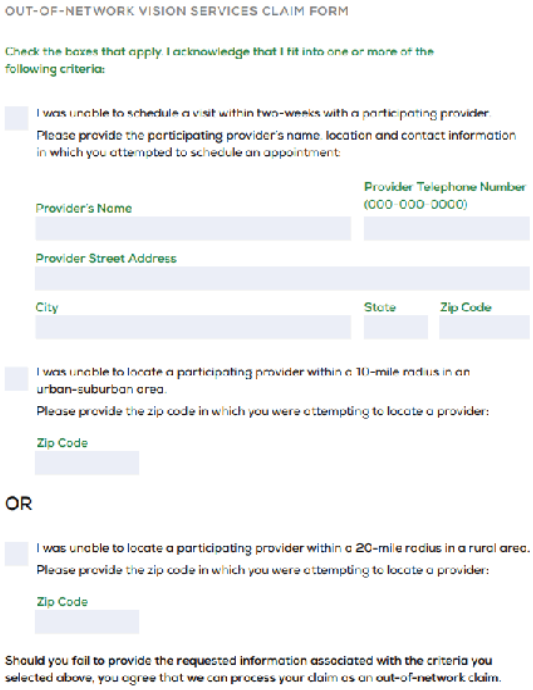

OUT-OF-NETWORK VISION SERVICES CLAIM FORM

Check the boxes that apply. I acknowledge that I fit into one or more of the following criteria:

☐ I was unable to schedule a visit within two-weeks with a participating provider.
Please provide the participating provider's name, location and contact information in which you attempted to schedule an appointment:

Provider's Name | Provider Telephone Number (000-000-0000)

Provider Street Address

City | State | Zip Code

☐ I was unable to locate a participating provider within a 10-mile radius in an urban-suburban area.
Please provide the zip code in which you were attempting to locate a provider:

Zip Code

OR

☐ I was unable to locate a participating provider within a 20-mile radius in a rural area.
Please provide the zip code in which you were attempting to locate a provider:

Zip Code

Should you fail to provide the requested information associated with the criteria you selected above, you agree that we can process your claim as an out-of-network claim.

Please Note: You will not be reimbursed for services and/or lenses at the out-of-network rate if you go to an out-of-network provider when an in-network provider is within 20 miles of where you live.

Vision Plan

Service	In-Network Coverage	Out-of-Network Reimbursement	Frequency
Exam, with dilation as necessary	$10 copay	up to $45	Once every plan year
Frames[1]	$0 copay, $130 allowance, 20% off balance over $130	up to $70	Once every plan year
Lenses (in place of contact lenses)			
Single Vision	$25 copay	up to $30	Once every plan year
Bifocal	$25 copay	up to $50	Once every plan year
Trifocal	$25 copay	up to $65	Once every plan year
Lenticular	$25 copay	up to $100	Once every plan year
Standard Progressive Premium Progressive Tiers 1-3[2] Premium Progressive Tier 4	$80 copay $100-125 copay $80 copay; 20% off Retail Price less $120 Allowance	up to $50 up to $50 up to $50	Once every plan year
Standard Lens Options UV Treatment Standard Polycarbonate (under age 19) Standard Plastic Scratch Coating Tint (Solid & Gradient)	 $0 copay $0 copay $0 copay $0 copay	 up to $5 up to $5 up to $5 up to $5	 Once every plan year Once every plan year Once every plan year Once every plan year
Standard Polycarbonate (age 19 & over) Anti-Reflective Coating Tiers 1-2[3] Anti-Reflective Coating Tier 3 Photochromic (Plastic)	$40 $45-$68 $75 $75	N/A N/A N/A	Once every plan year
All other lens options	20% off retail price	N/A	Once every plan year
Standard Contact Lens Fit and Follow-Up Premium Contact Lens Fit and Follow-Up	$40 10% off retail price	N/A N/A	Contact lens fit and two follow-up visits are available every plan year (once a comprehensive eye exam has been completed)
Elective Contact Lenses (in place of eyeglass lenses Contacts - Conventional	up to $130 allowance $0 copay; 15% off balance over $130 allowance	up to $105	Once every plan year
Medically Necessary Contact Lenses (in place of eyeglass lenses)	$0 copay, covered in full	up to $210	Once every plan year
Retinal Imaging Benefit	up to $39	N/A	Once every plan year

[1]20% off the balance when patients choose a frame that exceeds the allowance. Available from all in-network providers.

[2] & [3] Discuss your lens options with your in-network provider.

Your beneFIT Well-Being Program

The South Dakota State Employee Benefits Program partners with StayWell to provide tools and resources to help you take charge of your health. Complete the online Health Assessment to determine your health status and then check out the educational videos, healthy recipes, motivated coaching, and much more.

Pre-65 Retirees and COBRA members are welcome to participate in the wellness activities, but health plan choices are not impacted by completing the wellness opportunities. By participating in the beneFIT well-being program, you can take control of your health and set happiness in motion. To learn more, visit https://benefit.staywell.com.

Assistance is available at no cost to you

No matter your existing health, financial, mental, or social situation, there are things you can do to take better control of your health and well-being. Take advantage of the following programs available to you at no charge.

Preventive care

Preventing disease before it starts is critical to helping people live longer, healthier lives and keeping health care costs down. The earlier a serious medical condition is caught, the easier the treatment.

Preventive services can help those dealing with early stages of a disease to keep from getting sicker. Your Health Plan covers eligible preventive care at 100% appropriate for your age:

- Well Child Care
- Annual Wellness Exam
- Well Woman Preventive Visit
- Cancer Screening Procedures
- Scheduled Immunizations and Vaccinations

Members receive one annual wellness preventive exam covered by the health plan each plan year.

Preventive tests are one of the many benefits of the annual wellness exam. Cholesterol tests, depression screenings, Type 2 diabetes screenings, and blood pressure tests are all available.

Cancer screenings are also covered for certain ages and frequencies.

For a detailed description of what is covered and when, go to https://bhr.sd.gov/benefits/active/health-plans/preventative-care/ or call 800.831.0785.

Health Management Partners

Do you need help managing a health condition? Receive no cost coaching, education, and guidance if you have any of the targeted conditions listed below. These programs are available to any member covered by the health plan. Visit https://bhr.sd.gov/benefits/active/benefit/conditions-management/ or call 866.330.9886 to inquire about the following services:

- Health Conditions Management
- Case Management
- Our Healthy Baby

Contacts and Resources

The South Dakota State Employee Benefits Program 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.

DAKOTACARE	CONTACT	ONLINE	PHONE / FAX
• Coverage questions • Provider Network • Claims Processing	DAKOTACARE 5300 S. Broadband Ln Sioux Falls, SD 57108	www.DAKOTACARE.com DAKOTACARE Access https://access.dakotacare.com/ Network look up: https://www.dakotacare.com/services/find-a-provider-state-employees/	1.800.831.0785 Fax: 605.274.3291 (Attn: Claims)
South Dakota State Employee Benefits Program			
• Health Plan Questions • Enrollment Questions	Bureau of Human Resources 500 E Capitol Ave Pierre, SD 57501	benefitswebsite@state.sd.us https://bhr.sd.gov/benefits/	605.773.6027 Fax: 605.773.6840
beneFIT Well-Being Program			
• Online Health Assessment • Onsite Health Screening • Wellness Programs	StayWell Health Management 3000 Ames Crossing Rd. St. Paul, MN 55121	https://benefit.staywell.com	1.800.721.2749
Health Management Partners (HMP)			
• Case Management • Condition Management • Medical Pre-authorizations • Medical Management • Our Healthy Baby	Health Management Partners 2301 W Russell St. Sioux Falls, SD 57105	https://sosd.hmpsdportal.com www.preauthonline.com	1.866.330.9886 Fax: 605.731.1905
Discovery Benefits			
• Health Savings Accounts	Discovery Benefits PO Box 2926 Fargo, ND 58108	customerservice@discoverybenefits.com www.discoverybenefits.com	1.866.451.3399 Fax: 1.866.451.3245

Suicide Prevention

If you or someone you know needs help, call 800.273.8255 to access the Suicide Prevention Helpline 24/7. For more information on suicide warning signs and support, please visit sdsuicideprevention.org/.

Contacts and Resources

Delta Dental	CONTACT	ONLINE	PHONE / FAX
• Dental	Delta Dental PO Box 1157 Pierre, SD 57501	www.deltadentalsd.com https://bhr.sd.gov/benefits/active/flexible-benefits/dental-plans/	605.224.7345, 1.877.841.1478
EyeMed			
• Vision	EyeMed 4000 Luxottica Place Mason, OH 45050	https://eyemedvisioncare.com/sosd/ https://bhr.sd.gov/benefits/active/flexible-benefits/vision-plans/	1.888.626.6334
MetLife			
• Accident Insurance • Hospital Indemnity • Short Term Disability • Life Insurance and AD&D	MetLife 200 Park Ave New York, NY 10166	www.metlife.com/southdakota/ https://bhr.sd.gov/benefits/	1.800.GET.MET8, 1.800.438.6388
Risty Benefits, Inc			
• Long Term Care - UNUM	Risty Benefits, Inc. 1324 Minnesota Sioux Falls, SD 57105	help@ristybenefits.com	1.866.237.9411
South Dakota Retirement System			
• Retirement Planning • Supplemental Retirement Planning • Career & Financial Planning Workshops	South Dakota Retirement System P.O. Box 1098 Pierre, SD 57501	https://sdrs.sd.gov/contact.aspx	605.773.3731, 1.888.605.7377

Tobacco Cessation

Need help quitting tobacco? Receive a quit guide, free cessation medication, and assistance from a health coach. Call 866.737.8487or go to www.sdquitline.com/.

SD State Employee Health Plan
Hillsview Building
3800 East Highway 34, Suite 1
Pierre, SD 57501-5714
605.773.3148

SOUTH DAKOTA state employee benefits program

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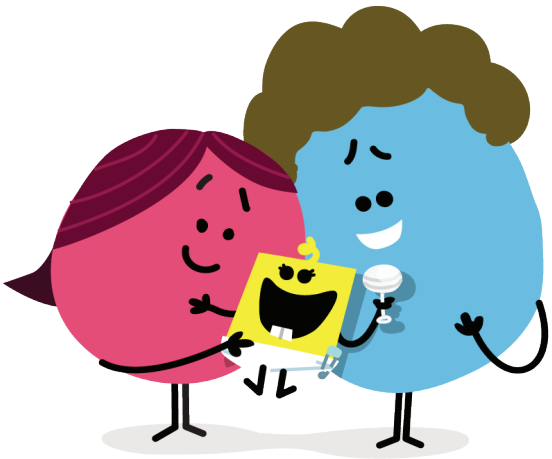

Annual Enrollment: May 6 - 20, 2020

FY21 Plan Year: July 1, 2020 - June 30, 2021