



ANNUAL ENROLLMENT DATES: MAY 8-22, 2019

FY20 Decision Guide

Retiree/COBRA

FY20 (July 1, 2019 - June 30, 2020)

SOUTH DAKOTA
state employee
benefits program

learn. act. thrive.

FY20 Retiree/COBRA Guide & Reference Manual

South Dakota State Employee Benefits Program

Enroll in Benefits: May 8-22, 2019

Annual Enrollment is May 8-22, 2019. This is the only time during the plan year that you can make changes to your health, dental and vision benefits without a valid family status change.

You must currently have coverage for health, dental, and/or vision to make changes. If you have coverage, you can add your spouse and/or dependent(s) to the plan(s).

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

If you do not send anything in during Annual Enrollment, your health, dental and/or vision plan(s) will remain the same.

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Compliance Documents

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

What's new in FY20

- The Low Deductible Health Plan now has a \$1,500 deductible for single coverage and \$3,750 deductible for family coverage (for a family of three or more).
- The Low Deductible Health Plan has a separate prescription deductible from the medical deductible above. For FY20, the prescription deductible will increase \$50 to \$150, and the individual out-of-pocket maximum will increase \$500 to \$1,500. The family out-of-pocket will increase \$1,250 to \$3,750.
- The out-of-pocket maximum on the Low Deductible Health Plan will increase by \$300 to \$4,400 for single coverage or any one family member. The out-of-pocket maximum for a family of three or more will increase by \$750 to \$9,375.
- The High Deductible Health Plan now has a \$2,200 deductible for the single coverage, and \$4,400 deductible for family coverage (for a family of two or more).
- The out-of-pocket maximum on the High Deductible Health Plan will increase by \$300 to \$5,300 for single coverage or any one family member. The out-of-pocket maximum for a family of two or more will increase by \$750 to \$10,275.
- Prescription drug copayments have increased across several tiers for both the Low Deductible Health Plan and High Deductible Health Plan. See page 4-5 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/index.html>.
- 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.

Low Deductible Health Plan

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

- The Low Deductible Health Plan deductible will be \$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.

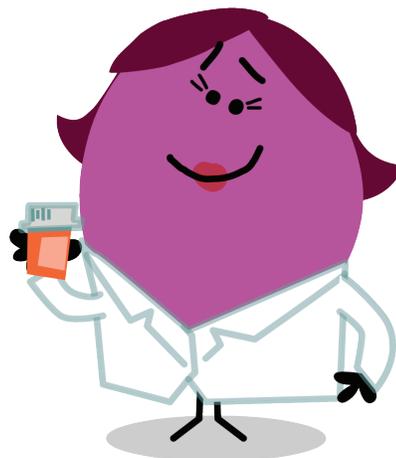
How Prescription Drug Coverage Works

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).
- 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 an HSA to allow you to pay for covered medical expenses with pretax dollars.
- 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>



FY20 Health Plan Comparison

Below is a comparison chart to help you understand the differences, similarities and costs of the two Health Plans available to you and your family.

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY20				
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	<ul style="list-style-type: none"> \$1,500 per person \$3,750 per family of three or more⁴ 	<ul style="list-style-type: none"> \$3,000 per person \$7,500 per family of three or more 	<ul style="list-style-type: none"> \$2,200 single coverage \$4,400 family coverage per family of two or more 	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> Emergency Room: \$250 Does not count toward your deductible but does count toward your out-of-pocket maximum. 		N/A	
Coinsurance	<ul style="list-style-type: none"> Plan pays 75% after deductible You pay 25% 	<ul style="list-style-type: none"> Plan pays 65% after deductible You pay 35% 	<ul style="list-style-type: none"> Plan pays 75% after deductible You pay 25% 	<ul style="list-style-type: none"> Plan pays 65% after deductible You pay 35%
Plan Year Out-of-Pocket Maximum (includes deductible)	<ul style="list-style-type: none"> \$4,400 per person \$9,375 per family of three or more 	<ul style="list-style-type: none"> \$8,300 per person \$18,250 per family of three or more 	<ul style="list-style-type: none"> \$5,300 single coverage or any one family member \$10,275 family coverage per family of two or more 	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> \$1,500 per person \$3,750 per family of three or more 		Included in Plan Year Out-of-Pocket Maximum	

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

²To view eligible preventive care services, visit <http://bhr.sd.gov/benefits/active/health-plans-preventative-care/>.

³When 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.

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

FY20 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.

FY20 RETIREE MONTHLY CONTRIBUTION RATES

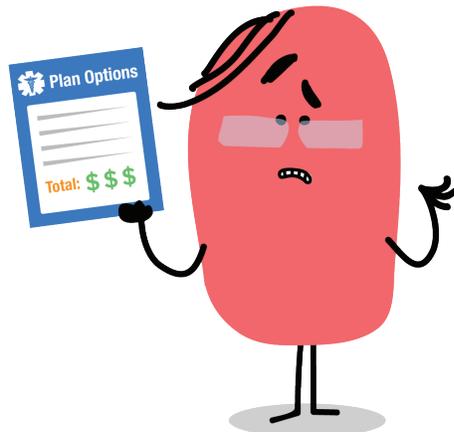
Coverage Level	Low Deductible Plan (\$1,500)	High Deductible Plan - HSA Compatible (\$2,200/\$4,400)
Retiree	\$2,239.47	\$1,074.41
Retiree + Spouse	\$4,891.59	\$2,005.53
Retiree + Child(ren)	\$2,817.59	\$1,296.70
Family	\$5,469.72	\$2,227.80

NOTE: Contributions for retiree and spouse surcharge will increase \$60 per person per month if retiree and/or covered spouse use tobacco.

FY20 COBRA MONTHLY CONTRIBUTION RATES

Coverage Level	Low Deductible Plan (\$1,500)	High Deductible Plan - HSA Compatible (\$2,200/\$4,400)
Participant Only	\$634.89	\$595.10
Participant + Spouse	\$1,371.19	\$1,284.82
Participant + Child(ren)	\$975.39	\$916.19
Family	\$1,711.04	\$1,605.24

NOTE: Contributions for retiree and spouse surcharge will increase \$60 per person per month if retiree and/or covered spouse use tobacco.



FY20 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.
- Additional dental plan information is available at <https://bhr.sd.gov/benefits/active/flexible-benefits/dental-plans/>.
- 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 Account²		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)



- 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.



Smile Smart for your Health

If you or someone on your dental plan has any of the following health conditions, you/they are eligible for additional benefits (per coverage year) through the Smile Smart for Your Health program.

- Gum (periodontal) disease (4 cleanings*, 2 applications of fluoride varnish)
- Diabetes (4 cleanings*)
- Pregnancy (1 additional cleaning during the time of pregnancy)
- High-risk cardiac conditions (4 cleanings*)
- Kidney failure or undergoing dialysis (4 cleanings*)
- Undergoing cancer-related chemotherapy and/or radiation(4 cleanings*, 2 applications of fluoride varnish)
- Suppressed immune systems (4 cleanings*, 2 applications of fluoride varnish)
- At risk for oral cancer (brush biopsy test for early detection of oral cancer/precancerous cells)

Let your dentist know and he/she will note the condition on your claim form. If you have questions regarding this program call Delta Dental's customer service at 605.224.7345 or 877.841.1478.

* Cleanings can either be a general (prophylaxis) cleaning or a periodontal maintenance cleaning. Periodontal maintenance cleanings are covered under the "Routine and Restorative" category, not the "Diagnostic and Preventive Services" category. Your dentist may or may not charge for exams related to added periodontal maintenance or cleanings. The additional exams are not covered.

Vision Plan

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 enroll.eyemed.com, clicking on 'Find a Provider', entering your zip code, and choosing the network, Insight. Walmart is also an in-network provider.
- **Call EyeMed at 888.626.6334 to answer any benefit questions and confirm your provider options.**

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

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 continued 1

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 (OOO-OOO-OOOO)

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 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. For example, members who live in Pierre can purchase corrective lenses at Wal-Mart at in-network rates. However, because Pierre has no in-network provider for services, members receive reimbursement at the in-network rates when using out-of-network providers for exams.

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	\$80 copay	up to \$50	Once every plan year
Premium Progressive Tiers 1-3 ²	\$100-125 copay	up to \$50	
Premium Progressive Tier 4	\$80 copay; 20% off Retail Price less \$120 Allowance	up to \$50	
Standard Lens Options			
UV Treatment	\$0 copay	up to \$5	Once every plan year
Standard Polycarbonate (under age 19)	\$0 copay	up to \$5	Once every plan year
Standard Plastic Scratch Coating	\$0 copay	up to \$5	Once every plan year
Tint (Solid & Gradient)	\$0 copay	up to \$5	Once every plan year
Standard Polycarbonate (age 19 & over)	\$40	N/A	Once every plan year
Anti-Reflective Coating Tiers 1-2 ³	\$45-\$68	N/A	
Anti-Reflective Coating Tier 3	\$75	N/A	
Photochromic (Plastic)	\$75	N/A	
All other lens options	20% off retail price	N/A	Once every plan year
Standard Contact Lens Fit and Follow-Up	\$40	N/A	Contact lens fit and two follow-up visits are available every plan year (once a comprehensive eye exam has been completed)
Premium Contact Lens Fit and Follow-Up	10% off retail price	N/A	
Elective Contact Lenses (in place of eyeglass lenses)	up to \$130 allowance	up to \$105	Once every plan year
Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance		
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

¹20% 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.

Take Charge of Your Health & Well-being



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.

Your beneFIT well-being program

Complete wellness qualifications to earn incentive for FY21

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.

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
- Pregnancy Care Preventive Screenings
- 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.

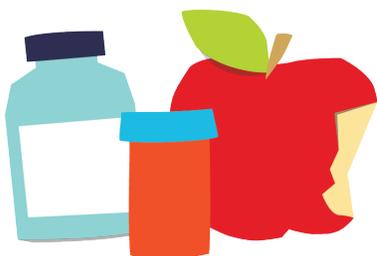
Additional Wellness Resources:

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/

Tobacco Cessation

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



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
<ul style="list-style-type: none"> • Coverage questions • Provider Network • Claims Processing 	DAKOTACARE 2600 West 49 Street Sioux Falls, SD 57105-6575	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			
<ul style="list-style-type: none"> • 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/	605.773.3148 Fax: 605.773.6840
benefIT Well-Being Program			
<ul style="list-style-type: none"> • 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)			
<ul style="list-style-type: none"> • Case Management • Condition Management • Medical Pre-authorizations • Medical Management • Our Healthy Baby 	Health Management Partners 2301 W Russell St. Sioux Falls, SD 57105	http://sosd.hmpsdportal.com www.preauthonline.com	1.866.330.9886 Fax: 605.731.1905
Discovery Benefits			
<ul style="list-style-type: none"> • Medical Flexible Spending Account • Dependent Care Spending Account • Health Savings Account • Health Reimbursement Account 	Discovery Benefits PO Box 2926 Fargo, ND 58108	customerservice@discoverybenefits.com www.discoverybenefits.com	1.866.451.3399 Fax: 1.866.451.3245



Contacts and Resources

Delta Dental	CONTACT	ONLINE	PHONE / FAX
<ul style="list-style-type: none"> • 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			
<ul style="list-style-type: none"> • Vision 	EyeMed 4000 Luxottica Place Mason, OH 45050	https://eyemedvisioncare.com/sosd/public/login.emvc https://bhr.sd.gov/benefits/active/flexible-benefits/vision-plans/	1.888.626.6334
MetLife			
<ul style="list-style-type: none"> • 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			
<ul style="list-style-type: none"> • Long Term Care - UNUM 	Risty Benefits, Inc. 1324 Minnesota Sioux Falls, SD 57105	help@ristybenefits.com	1.866.237.9411
South Dakota Retirement System			
<ul style="list-style-type: none"> • 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
CVS/Caremark			
<ul style="list-style-type: none"> • Call in new prescriptions 			866.443.1185