ANNUAL ENROLLMENT DATES: MAY 1–14, 2015

FY16 Decision Guide Retiree/COBRA

FY16 (July 1, 2015 - June 30, 2016)

SOUTH DAKOTA
state employee benefits program
learn. act. thrive.

FY16 Decision Guide

South Dakota State Employee Benefits Program

Welcome Message

Annual Enrollment is May 1-14, 2015. During this time, you can make changes to your Health, Dental and/or Vision benefit plans effective July 1, 2015. If you do not enroll during Annual Enrollment, your current elections will remain the same. This is the only time during the plan year you can make changes to your benefits without a valid family status change.

You can cancel your State Employee Health Plan coverage at any time. However, you will not be able to re-enroll in the health plan in the future.

For FY16, there are new vendors for the Dental and Vision plans. There are also new rate structures and monthly contribution rates. For your convenience, we included plan highlights, rates and plan specific information. The new Dental plan no longer carries a Vision benefit.

New Vendors include:

- Delta Dental –Dental Plan
- MetLife – Vision Plan

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).

Enroll in Benefits: May 1-14, 2015

1. Review Your Current Benefit Selections

- Refer to your personalized confirmation statement(s) enclosed with this Decision Guide.

2. What's New in FY16

- New contribution rates.
- New dental and vision vendors.
- New dental and vision rate structure.
- Pay attention to new flexible benefit offerings and view additional information online at http://benefits.sd.gov/retiree.aspx.

3. Enroll for FY16 Benefits

- To make changes, complete the enclosed form and return by May 14, 2015 to the South Dakota State Employee Benefits Program.
- If you do not enroll/complete the enrollment form during FY16 Annual Enrollment, your benefit selection(s) will remain the same as you currently have in FY15. Rates for FY16 will change depending on your Health Plan selection.

FY16 Health Plan

What You Need to Know About the Health Plan

- You must visit a DAKOTACARE network provider to receive the highest level of benefits.
- In some cases, Health Management Partners must pre-authorize services or referrals. To view the Pre-authorization Listing visit http://benefits.sd.gov, scroll over Forms/Documents and choose Forms/ Documents. The Pre-authorization Listing is in the Other section.
- Eligible preventive services are covered prior to satisfying your deductible. To view eligible preventive care services, visit http://benefits.sd.gov/preventivecare.aspx.
- Out-of-Network provider means:
  - A DAKOTACARE network provider did not provide care
  - You did not receive approval from Health Management Partners for a referral to an out-of-network provider
  - You failed to obtain pre-authorization when necessary
- Expenses not covered by the Health Plan do NOT apply to the out-of-pocket maximum.
- When insured under the $1,800 Deductible Health Plan, all costs of prescription drugs apply to the deductible and then coinsurance. There are no prescription copayments.

$750 Deductible Health Plan

- You must meet a $750 per person or a $1,875 family deductible (if you have coverage for a family of 3 or more).
- Copayment: Emergency Room $250.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-of-pocket maximum has been met.
- A separate prescription drug deductible of $50 per person applies before prescription drug copays begin.

$1,250 Deductible Health Plan

- You must meet a $1,250 per person or a $3,125 family deductible (if you have coverage for a family of 3 or more).
- Copayment: Emergency Room $250.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-pocket-maximum has been met.
- A separate prescription drug deductible of $50 per person applies before prescription drug copays begin.

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

- All eligible Health Plan expenses, including prescription drugs, apply toward meeting the deductible.
- There is a $1,800 deductible for single coverage and a $3,600 deductible for family coverage. The family deductible must be met by one or more individuals before any benefits will be paid.
- After the deductible has been met when using a DAKOTACARE network provider, 25% coinsurance applies until the out-pocket-maximum has been met.
- Members pay for prescription drug expenses upfront, which then apply to the deductible until the deductible has been met. After the deductible has been met, the member pays 25% coinsurance after reimbursement by DAKOTACARE. Members always pay upfront then will be reimbursed as eligible.
- Please consult with your financial planner or accountant for more information on a Health Savings Account.
- You do not need to set up a Health Savings Account to change to the $1,800 Deductible Health Plan.

HSA MAXIMUM CONTRIBUTION FOR FY16

You can make tax-free contributions to your HSA, up to limits established by the IRS. The following are the maximum contributions you can make to your HSA in FY16 according to IRS regulations.

	HSA Contribution 2015*
Participant only	$3,350
Participant and Spouse, Children or Family	$6,650

* Catch-up contributions are allowed for individuals age 55 or older and each individual age 55 or older can contribute an additional $1,000 in FY16. Consult your financial planner or accountant for more information.

FY16 Health Plan Comparison

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

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN COVERAGE DETAILS FOR FY16

Plan Details	$750 Deductible Health Plan		$1,250 Deductible Health Plan		$1,800 Deductible Health Plan with HSA	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Eligible Preventive Services[1]	Covered at 100%	Not covered[2]	Covered at 100%	Not covered[2]	Covered at 100%	Not covered[2]
Plan Year Deductible	• $750 per person • $1,875 per family of three or more	• $1,500 per person • $3,750 per family of three or more	• $1,250 per person • $3,125 per family of three or more	• $2,500 per person • $6,250 per family of three or more	• $1,800 single coverage • $3,600 family coverage If you have family coverage, the full family deductible must be met before benefits are paid for any family member.	• $3,600 single coverage • $7,200 family coverage
Copayment	• Emergency Room: $250		• Emergency Room: $250		N/A	
Coinsurance	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%	• Plan pays 75% after deductible • You pay 25%	• Plan pays 65% after deductible • You pay 35%
Plan Year Out-of-Pocket Maximum	• $3,250 per person • $8,125 per family of three or more	• $6,500 per person • $16,250 per family of three or more	• $4,250 per person • $10,200 per family of three or more	• $8,500 per person • $21,250 per family of three or more	• $4,350 single coverage • $10,200 per family	• $8,700 single coverage • $21,750 per family
Prescription Drugs						
Deductible	$50 per person	$50 per person	$50 per person	$50 per person	Included in Plan Deductible	
Pharmacy Out-of-Pocket Maximum	• $1,000 per person • $2,500 per family of three or more		• $1,000 per person • $2,500 per family of three or more		Included in Plan Year Out-of-Pocket Maximum	

[1] To view eligible preventive care services, visit http://benefits.sd.gov/preventivecare.aspx.

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

FY16 Prescription Drug Coverage

How Prescription Drug Coverage Works

- Under the $750 Deductible and $1,250 Deductible Health Plans there is a separate $50 deductible (per person, per plan year) for prescription drugs. Copayments apply after the deductible is satisfied. If the price is less than the defined copayment, you will pay the lesser of the two amounts.
- Under the $1,800 Deductible Health Plan with HSA, a single $1,800 deductible and family $3,600 deductible apply to both medical expenses and prescription drug expenses combined. Prescription drug coinsurance applies toward the out-of-pocket maximum after reimbursement by DAKOTACARE.
- If a physician indicates Dispense as Written (DAW) or if the member requests the brand name product when a generic is available, the member will pay the applicable copayment or coinsurance PLUS the difference between the brand name medication and the contracted rate. This cost difference is referred to as an ancillary charge.

FY16 Prescription Drug Plan

- The formulary list is available at http://benefits.sd.gov/Forms.aspx under the pharmacy section.
- Brand Preferred medications are products that contain no generic equivalent, but are recognized by the Pharmacy and Therapeutics Committee to be preferred treatment options on the basis of clinical outcomes.
- Specialty Preferred medications are prescription medications that are typically developed on DNA-based technologies. These medications require specialized management, monitoring and/or delivery. For more information, call DAKOTACARE at 800.831.0785.

PRESCRIPTION DRUG COVERAGE UNDER THE $750 DEDUCTIBLE AND $1,250 DEDUCTIBLE HEALTH PLANS	
Tiered Prescription Drug Coverage	Up to 30 Day Supply Copayment
Tier 1 - Generic	$10
Tier 2 - Brand Preferred	$40
Tier 3 - Brand Non-Preferred	$60
Tier 4 - Specialty Preferred	$60
Tier 5 - Specialty Non-Preferred	$85

PRESCRIPTION DRUG COVERAGE UNDER THE $1,800 DEDUCTIBLE HEALTH PLAN
Prescription Drug Coverage
Member pays full prescription drug expenses directly to the pharmacy at the time of service.
Pharmacy charges are applied to deductible:$1,800 single coverage or $3,600 family coverage.
After the deductible has been met, the member is responsible for 25% coinsurance up to the Plan Year Out-of-Pocket Maximum. Member then pays the full prescription drug expense with 75% reimbursement from DAKOTACARE.

FY16 Health Plan Contributions

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

Retiree Monthly Contribution Rates

MONTHLY CONTRIBUTION RATES (Effective 7/1/2015 through 6/30/2016)			
Coverage Level	$750 Deductible Plan Contributions*	$1,250 Deductible Plan Contributions*	$1,800 Deductible Plan with HSA Contributions*
Retiree	$962.56	$726.03	$461.80
Retiree + Child(ren)	$1,211.05	$946.68	$557.34
Retiree + Spouse	$2,102.49	$1,406.56	$862.01
Family	$2,350.98	$1,627.21	$957.55

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

COBRA Monthly Contribution Rates

MONTHLY CONTRIBUTION RATES (Effective 7/1/2015 through 6/30/2016)			
Coverage Level	$750 Deductible Plan Contributions*	$1,250 Deductible Plan Contributions*	$1,800 Deductible Plan with HSA Contributions*
Participation Only	$555.95	$536.98	$521.12
Participant + Child(ren)	$854.13	$825.91	$802.29
Participant + Spouse	$1,200.74	$1,159.56	$1,125.10
Family	$1,498.33	$1,447.89	$1,405.68

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

FY16 Dental Plans

- The Base and Enhanced Dental Plans are provided by Delta Dental.
- There is a $25 per plan year per member deductible.
- The Base and Enhanced Plans pay for services based on a percentage of allowable charges.
- The member is responsible for the deductible, charges that exceed the covered percentage of allowable charges and any charges over the annual maximum.
- No more than the noted dental maximum can be applied to dental benefits.
- Delta Dental offers an expanded dental network that includes 98% of the dentists in South Dakota.
- You can visit the dentist of your choice but you may owe less out-of-pocket when you go to a participating/network dentist. Participating/network dentists have agreed to write off charges that exceed the allowable charges; nonparticipating dentists can balance bill those charges back to the members.
- To find a participating/network dentist, visit www.deltadentalsd.com and click on Find a Dentist.
- If you enroll in either dental plan in FY16, there are no waiting periods for major and orthodontic services.
- Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $750 for the plan year. MBA maximum is $1,500 per member when enrolled in the Enhanced Plan.
- Additional dental plan information is available at http://benefits.sd.gov/dental.aspx.
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Base Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$30.56
Participant + Spouse	$61.02
Participant + Child(ren)	$66.79
Participant + Family	$97.25

Enhanced Dental Plan Premiums

Coverage Level	Monthly Premiums
Participant	$49.35
Participant + Spouse	$98.55
Participant + Child(ren)	$100.49
Participant + Family	$149.70

Dental Plan Overview

	Base Plan	Enhanced Plan
Annual Maximum	$1,000	$1,500
Deductible (per plan year per member)	$25	$25
Diagnostic and Preventive Services	no waiting period	no waiting period
Routine and Restorative Services	no waiting period	no waiting period
Major and Orthodontic Services	no waiting period for FY16 1 year waiting period after FY16	no waiting period for FY16 1 year waiting period after FY16
Maximum Bonus Account (MBA)	n/a	up to $1,500 per Enhanced Plan member

Dental Plan Coverage

Diagnostic and Preventive Services	Frequency	Base Plan Coverage [1]	Enhanced Plan Coverage[1]
Routine examinations	2 per plan year	75%	100%
Routine cleanings	2 per plan year	75%	100%
Bite-wing x-rays	1 per plan year	75%	100%
Full mouth x-ray	1 in 5 years	75%	100%
Fluoride treatments	2 per plan year up to age 19	75%	100%
Space maintainers	on primary posterior teeth up to age 14	75%	100%
Dental sealants	once for unrestored 1st and 2nd permanent molars of child(ren) up to age 16	75%	100%
Routine and Restorative Services	**Frequency**	**Base Plan Coverage [1]**	**Enhanced Plan Coverage[1]**
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[2]	**Frequency**	**Base Plan Coverage [1]**	**Enhanced Plan Coverage[1]**
Root canals	1 every 2 years per tooth	35%	50%
Treatment of gum disease (periodontal service)	surgical-once every 3 years nonsurgical-once every 2 years	35%	50%
Crowns/onlays	1 every 5 years	35%	50%
Bridges	1 every 5 years	35%	50%
Partial and complete dentures	1 every 5 years	35%	50%
Implants	1 every 5 years	35%	50%
Surgical extractions	n/a	35%	50%
Orthodontics[2]		50% up to age 19 only	50%
Lifetime orthodontic benefit		$1,000	$1,500
Maximum Bonus Account[3]		n/a	$1,500

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

[2] Members who enroll during FY16, will not have waiting periods. Members who do not enroll when initially eligible, will be subject to one year waiting periods for major and orthodontic services.

[3] Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $750 for the plan year. MBA maximum is $1,500 per member.

Dental Maximum Bonus Account (MBA)

- Members enrolled in the Enhanced Plan are eligible to receive $250 per plan year in Maximum Bonus Account (MBA) benefits if they file at least one claim during the plan year and benefits paid are less than $750 for the plan year.
- The MBA maximum is $1,500 per member.
- You must be enrolled in the Enhanced Plan for one plan year before you can earn MBA benefits.
- You, your spouse and dependents will each have their own account. MBA benefits cannot be shared.
- MBA benefits can not be used for orthodontic claims.
- 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.
- If you are currently enrolled in the Enhanced Plan, your dental rewards balance will carryover to Delta Dental if you enroll in the Enhanced Plan and see a dentist at least once during FY15 plan year.
- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Dental Plan Coverage Examples

Base Plan: Example 1

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

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

Enhanced Plan: Example 1

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

Code	Description	Charged	Approved	DDS Writeoff	Deductible	Covered %	Plan Pays	Patient Pays
D0120	Examination	$50.00	$45.00	$5.00	$25.00	100%	$20.00	$25.00
D0272	Bitewing x-rays (2)	$45.00	$41.00	$4.00	$-	100%	$41.00	$-
D1110	Child cleaning	$65.00	$60.00	$5.00	$-	100%	$60.00	$-
D1206	Fluoride varnish	$35.00	$35.00	$-	$-	100%	$35.00	$-
D1351	Dental sealant	$50.00	$47.00	$3.00	$-	100%	$47.00	$-
D1351	Dental sealant	$50.00	$47.00	$3.00	$-	100%	$47.00	$-
	Total	$295.00	$275.00	$20.00	$25.00		$250.00	$25.00

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

Dental Plan Coverage Examples

Base Plan: Example 2

Example 2 shows an adult who had a dental exam, x-rays, cleaning, three fillings, a root canal and a crown.

The Base Plan $1,000 annual maximum benefit has been reached in this example.

Code	Description	Charged	Approved	DDS Writeoff	Deductible	Covered %	Plan Pays	Patient Pays
D0150	Examination	$70.00	$66.00	$4.00	$25.00	75%	$30.75	$35.25
D0274	Bitewing x-rays (4)	$60.00	$55.00	$5.00	$-	75%	$41.25	$13.75
D0220	Periapical x-ray	$30.00	$27.00	$3.00	$-	75%	$20.25	$6.75
D1110	Adult cleaning	$90.00	$82.00	$8.00	$-	75%	$61.50	$20.50
D2330	Composite filling	$150.00	$135.00	$15.00	$-	60%	$81.00	$54.00
D2330	Composite filling	$150.00	$135.00	$15.00	$-	60%	$81.00	$54.00
D2392	Composite filling	$200.00	$200.00	$-	$-	60%	$120.00	$80.00
D3330	Root canal	$850.00	$850.00	$-	$-	35%	$297.50	$552.50
D2750	Crown	$850.00	$850.00	$-	$-	35%	$266.75	$583.25
	Total	$2,450.00	$2,400.00	$50.00	$25.00		$1,000.00	$1,400.00

Enhanced Plan: Example 2

Example 2 shows an adult who had a dental exam, x-rays, cleaning, three fillings, a root canal and a crown.

The Enhanced Plan has $69 remaining of the $1,500 annual maximum benefit plus MBA carryover funds, if applicable.

Code	Description	Charged	Approved	DDS Writeoff	Deductible	Covered %	Plan Pays	Patient Pays
D0150	Examination	$70.00	$66.00	$4.00	$25.00	100%	$41.00	$25.00
D0274	Bitewing x-rays (4)	$60.00	$55.00	$5.00	$-	100%	$55.00	$-
D0220	Periapical x-ray	$30.00	$27.00	$3.00	$-	100%	$27.00	$-
D1110	Adult cleaning	$90.00	$82.00	$8.00	$-	100%	$82.00	$-
D2330	Composite filling	$150.00	$135.00	$15.00	$-	80%	$108.00	$27.00
D2330	Composite filling	$150.00	$135.00	$15.00	$-	80%	$108.00	$27.00
D2392	Composite filling	$200.00	$200.00	$-	$-	80%	$160.00	$40.00
D3330	Root canal	$850.00	$850.00	$-	$-	50%	$425.00	$425.00
D2750	Crown	$850.00	$850.00	$-	$-	50%	$425.00	$425.00
	Total	$2,450.00	$2,400.00	$50.00	$25.00		$1,431.00	$969.00

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

Smile Smart for Your Health

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

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

*Periodontal maintenance cleanings are covered under the Routine and Restorative Services category, not the Diagnostic and Preventive category. Your dentist may or may not charge for extras related to added periodontal maintenance or cleanings. The additional exams are not covered.

- Questions? Call Delta Dental at 605.224.7345 or 877.841.1478.

Vision Plan

- The Vision Plan is provided by MetLife.
- The Vision Plan covers a wide range of services such as eye exams, glasses and contact fittings.
- Services covered under the Vision Plan are based on the date of service, not plan year.
- You can see the vision care doctor of your choice but you may pay the lowest out-of-pocket cost if you visit an In-Network provider.
- You can find an In-Network provider by visiting www.metlife.com, clicking on Find a Vision Provider, entering your zip code, and selecting MetLife Vision PPO as the plan.
- Questions? Call MetLife at 800.GET.MET 8 (800.438.6388).

Coverage Level	Monthly Premiums
Participant	$6.53
Participant + Spouse	$13.08
Participant + Child(ren)	$11.08
Participant + Family	$18.26

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

[1] 20% off the additional amount when patients choose a frame that exceeds the allowance. Available from all In-Network providers except Costco.

Contacts and Resources

The South Dakota State Employee Health Plan works in partnership to provide high quality, competitively priced programs, and services. Below is a listing of our contacts and resources and the services they offer.

	CONTACT	ONLINE	PHONE/FAX
Benefits Program			
• Health Plan Questions • Enrollment Questions	Bureau of Human Resources 500 East Capitol Pierre, SD 57501	benefitswebsite@state.sd.us http://benefits.sd.gov	605.773.3148 Fax: 605.773.6840
Latitude Wellness Programs			
• Health Assessment • Health Screenings • Latitude Wellness Program	Health Management Partners 2301 West Russell St. Sioux Falls, SD 57104	latitude@state.sd.us http://benefits.sd.gov and choose Latitude Wellness Portal	866.330.9886
DAKOTACARE			
• Coverage Questions • Provider Network • Flexible Spending Accounts • Claims Processing	DAKOTACARE P.O. Box 7406 Sioux Falls, SD 57117-7406	www.DAKOTACARE.com DAKOTACARE Flex Online www.dakotacareflexonline.com DAKOTACARE Access https://access.dakotacare.com/?Client=DD10028	800.831.0785 Fax: 605.336.0270 (Attn: Claims)
Health Management Partners			
• Case Management • Condition Management • Medical Pre-authorizations • Medical Management • Our Healthy Baby	Health Management Partners 2301 West Russell St. Sioux Falls, SD 57105	http://sosd.hmpsdportal.com www.preauthonline.com	866.330.9886 Fax: 605.731.1905
Delta Dental			
• Dental	Delta Dental PO Box 1157 Pierre, SD 57501	www.deltadentalsd.com http://benefits.sd.gov/dental.aspx	605.224.7345 or 877.841.1478
MetLife			
• Vision	MetLife 200 Park Avenue New York, NY 10166	www.metlife.com http://benefits.sd.gov/vision.aspx	800.GET.MET 8 or 800.438.6388
Risty Benefits, Inc.			
• Long Term Care • Life Insurance and AD&D	Risty Benefits, Inc. 1324 Minnesota Sioux Falls, SD 57105	help@ristybenefits.com www.southdakotaflexbenefits.com	866.237.9411

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