

# **LATITUDE WELLNESS AND PREVENTION**

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## ***LATITUDE WELLNESS AND PREVENTION***

The State of South Dakota offers Latitude, a free wellness and prevention program, to all Members on all three Health Plans.

Health is a deeply personal issue and not easily shared with an employer or even a health plan advocate, but positive lifestyle or attitude changes are an important part of good health. Health Management Partners (HMP) is working with the State to provide Latitude Wellness Programs.

As an employer, our responsibilities include:

- Offering wellness and prevention programs;
- Engaging employees;
- Personalizing wellness program options; and
- Supporting behavior changes.

As an employee, your responsibilities include:

- Participating in Latitude Programs;
- Setting personal goals; and
- Improving healthy behaviors.

South Dakota State Employee Health Plan Members who may enroll in Latitude Wellness Programs include:

- Employees;
- Covered spouses of Employees;
- Retirees and their covered spouses under the age of 65;
- COBRA members and their covered spouses; and
- Dependent Children (Asthma and Diabetes Condition Management only).

## ***HEALTH SCREENINGS***

Completing a Health Screening is one requirement of the lowest deductible plan in FY16 which must be completed during FY15. The Health Screening is a face to face appointment to assess your biometric measurements. Health Screenings are scheduled from July 1 to December 31, in various locations across the state.

**Your Health Screening includes:**

- Cholesterol (Total, HDL, LDL, Triglycerides, TC/HDL Ratio)
- Blood Pressure
- Body Mass Index

The annual Health Screenings are offered to Members at no charge. You may locate more program information by visiting <http://benefits.sd.gov/HealthScreenings.aspx>.

## ***HEALTH ASSESSMENT***

Completing a Health Assessment is one requirement of the lowest deductible plan in FY16 which must be completed during FY15. The online Health Assessment is available between January 1 to March 31.

The Health Assessment is confidential and takes about 15 minutes to complete.

Based on your responses, you receive a personalized report of your current health with tips on how to prevent or reduce your individual health risks for diabetes, cardiovascular disease, and other conditions. You may locate more program information by visiting <http://benefits.sd.gov/HealthAssessment.aspx>.

### ***LATITUDE WELLNESS PROGRAM***

Earning 75 Latitude Wellness Program points is one requirement of the lowest deductible plan in FY16 which must be completed during FY15. You can earn points for items completed between April 1, 2014 and March 31, 2015.

- You can do any combination of Latitude Wellness Programs to earn points.
- Each program is assigned a specific point value.
- Points update automatically once you have completed online tracking or submitted your proof of completion.
- If you are actively participating in condition management, your points will update automatically. HMP Enrollment Programs are worth 75 points.

You can locate more program information by visiting <http://benefits.sd.gov/Latitude.aspx>.

## ***CONDITION MANAGEMENT***

Five programs are available to Members with the following chronic health conditions:

- **Asthma;**
- **Pain;**
- **Diabetes;**
- **Cardiovascular; and**
- **Kidney Care**

Health Management Partners provides the condition management programs for plan members. You may locate more program information by visiting <http://benefits.sd.gov/ConditionManagement.aspx>.

### **Asthma Condition Management Program**

The Asthma program is designed to prevent hospital admissions by promoting self-management skills and adherence to treatment guidelines. This program has four focus areas including:

- Education to enhance understanding and compliance;
- Benefits of exercise;
- Symptom Management; and
- Tobacco cessation.

Respiratory Therapists will provide coaching for members in the following areas:

- Medication comprehension and compliance;
- Symptom management to prevent exacerbations;
- Proper use and maintenance of respiratory equipment;
- Identify early warning signs and develop action plan;
- Reinforce and practice breathing exercises and improve exercise tolerance;
- Identify triggers and develop coping strategies; and
- Break away from tobacco dependency with one-on-one support.

The Asthma program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

#### **Program Incentives:**

As an engaged member, your program incentives are determined by your risk stratification level.

#### **Stratification Levels:**

##### **High Risk: Level 3**

- 2 Telephonic coaching calls per month
- 1 “Asthma only” office visit per plan year
- Educational Material available when appropriate
- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

**Medium Risk: Level 2**

- 1 telephonic coaching call per month
- 1 “Asthma only” office visit per plan year
- Educational Material available when appropriate
- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

**Low Risk: Level 1**

- 4 telephonic coaching calls per year
- 1 “asthma only” office visit per plan year
- Educational Material available when appropriate
- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

**Stratification:**

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

**Program Incentives CPT Codes:**

The following will be paid at 100% when provided by an in-network provider:

- Asthma only office visit. Office visit must have one of the following-CPT codes:
  - 99201-99205
  - 99211-99215
  - 99241-99245
  - 99381-99404
- The diagnosis code below must be used.
  - 496
  - 493.XX
  - V70.0
  - V82.9

**Pain Condition Management**

The Pain program is designed to promote recovery from chronic pain and prevent future chronic pain issues. This program focuses on following areas:

- Symptom specific education
- Proper instruction for endurance, strength, and flexibility
- Assessment and optimization of body mechanics and posture
- Alternative measures

A health coach will provide coaching for members in the following areas:

- Injury/re-injury prevention education
- Appropriate pain management strategies
- Personalized stretching and strengthening plans
- Reinforcement of therapy goals and instructions
- Goal-setting and recovery planning

- Stress management and relaxation techniques
- Medication review
- Review of occupational workstation ergonomics

The Pain program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

**Program Incentives:**

As an engaged member, your program incentives are determined by your risk stratification level.

**High Risk: Level 3**

- Two telephonic coaching calls per month
- One office visit per plan year with a pain specialist
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

**Medium Risk: Level 2**

- Monthly telephonic coaching calls per month
- One office visit per plan year with a pain specialist
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

**Low Risk: Level 1**

- Four telephonic coaching calls per year
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

**Stratification:**

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

**Program Incentive CPT Codes:**

The Pain Management program is specific to the condition the member presents. Due to the varied nature of the conditions that may fall under this program, the member’s Health Coach, in collaboration with the HMP Clinical Management will determine the medical appropriateness of a Certified Pain Specialist appointment. This will be based upon the member’s presented condition or diagnosis. The Health Coach will assist in coordinating and completing the pre-authorization prior to the Pain Specialists and/or Physical Therapy appointments.

Preauthorization of the services will be required. Incentives include:

- 1 visit to a pain specialist, office visit CPT codes 99201-99215 will be considered eligible for benefit. Any additional services such as x-ray, scans, lab work will be considered under the provisions of the member’s health plan at their regular plan benefits.
- Up to 2 Physical Therapy visits that will educate the member on home therapy programs, eligible CPT codes are:

- 97110
- 97535
- 97530

## **Diabetes Condition Management**

The Diabetes Program is designed to improve self-management skills and promote adherence to treatment guidelines to reduce the risk of diabetes-related complications. This program is available for members diagnosed with diabetes or pre-diabetes and has four focus areas including:

- Education to enhance understanding and compliance
- Benefits of exercise
- Nutrition counseling
- Tobacco cessation

A Health Coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Optimizing physical activity levels to meet recommended guidelines
- Nutrition counseling for carbohydrate counting and weight management
- Blood pressure and cholesterol management
- Self blood glucose monitoring and recognizing signs of low and high blood glucose levels
- Break away from tobacco dependency with one-on-one support

The Diabetes program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

### **Program Incentives:**

As an engaged member, your program incentives are determined by your risk stratification level.

#### **High Risk: Level 3**

- Two telephonic coaching calls per month
- Up to 3 office visits per plan year
- Up to 3 HbgA1C-per plan year
- Up to 2 Lipid profile per plan year
- Up to 3 Visits to a Registered Dietician per plan year
- 1 Urine for protein/creatinine
- 2 Comprehensive Metabolic Panels (includes a fasting blood sugar & Serum Creatinine) per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

#### **Medium Risk: Level 2**

- 1 telephonic coaching call per month
- Up to 2 office visits per plan year
- Up to 2 HbgA1C per plan year
- Up to 2 Lipid profile per plan year
- Up to 2 Comprehensive Metabolic Panels (includes a fasting blood sugar & Serum Creatinine) per plan year

- Up to 2 Visits to a Registered Dietician per plan year
- 1 Urine for protein/creatinine per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

**Low Risk: Level 1**

- 4 telephonic coaching calls per year
- 1 office visit per plan year
- 1 HbgA1C per plan year
- 1 Lipid profile per plan year
- 1 Visit to a Registered Dietician per plan year
- 1 Comprehensive Metabolic Panel (includes fasting blood sugar & Serum Creatinine) per plan year
- 1 Urine for protein/creatinine per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

**Stratification:**

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

**Program Incentive CPT Codes:**

The following will be paid at 100% when provided by an in-network provider:

- Office visits (height, weight, and blood pressure required). Office visit must have one of the following-CPT codes:
  - 99201-99205
  - 99211-99215
  - 99241-99245
  - 99381-99404
- HbgA1C (glucose 3 month average)
  - CPT Code: 83036
- Lipid profile (cholesterol, HDL, LDL, and triglycerides)
  - CPT Codes: 80061 and/or 82465
- Comprehensive Metabolic Panel
  - CPT Codes: 80053
- Urine for protein/creatinine
  - CPT Codes: 84156 and/or 82570
- Annual retinal exam (by Physician or Optometrist)
  - CPT Codes: 92002 and/or 92004
  - 92014
  - 92012
  - 99211-99212

- One of the following diagnosis codes must be used:
  - 250.XX
  - 277.7
  - 790.21
  - 790.22
  - 790.29
  - V70.0
  - V70.9
  - V77.1
  - V77.9
  - V77.91
  - V77.99
  - V82.9

## **Cardiovascular Condition Management**

The Cardiovascular program is designed to improve self-management skills and promote adherence to treatment guidelines in order to reduce the risk of heart attacks and hospital admissions. This program has four focus areas including:

- Education to enhance understanding and compliance
- Benefits of exercise
- Nutrition counseling
- Tobacco cessation

A health coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Fluid and sodium restrictions as recommended by the treating physician
- Optimizing physical activity levels to meet recommended guidelines
- Healthy nutrition and weight management counseling
- Blood pressure and cholesterol management
- Self-monitoring for signs and symptoms of a cardiac event
- Break away from tobacco dependency with one-on-one support

The Cardiovascular program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

### **Program Incentives:**

As an engaged member, your program incentives are determined by your risk stratification level.

### **Stratification Levels:**

#### **High Risk: Level 3**

- 2 telephonic coaching calls per month
- Up to 3 office visits per plan year
- Up to 2 Lipid profile per plan year
- 1 Urine for protein/creatinine per plan year
- Up to 2 Comprehensive Metabolic Panels (includes fasting blood sugar) per plan year
- Educational material available when appropriate

**Medium Risk: Level 2**

- 1 telephonic coaching call per month per plan year
- Up to 2 office visits per plan year
- Up to 2 Lipid profile per plan year
- Educational material available when appropriate
- Up to 2 Comprehensive Metabolic Panels (includes fasting blood sugar) per plan year
- 1 Urine for protein/creatinine per plan year

**Low Risk: Level 1**

- 4 telephonic coaching calls per year
- 1 office visit per plan year
- 1 Lipid profile per plan year
- 1 Comprehensive Metabolic Panel (includes fasting blood sugar) per plan year
- 1 Urine for protein/creatinine per plan year
- Educational material available when appropriate

**Stratification:**

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

**Program Incentive CPT Codes:**

The following will be paid at 100% when provided by an in-network provider:

- Office visits (height, weight, and blood pressure required). Office visit must have one of the following CPT Codes:
  - 99201-99205
  - 99211-99215
  - 99241-99245
  - 99381-99404
- Lipid profile (cholesterol, HDL, LDL, and triglycerides)
  - CPT Codes: 80061 and/or 82465
- Comprehensive Metabolic Panel
  - CPT Code 80053
- Urine for protein/creatinine
  - CPT Codes: 84156, 82570
- One of the following diagnosis codes must be used:
  - 272.0-272.4
  - 401.XX-414.9
  - 796.2
  - V70.0
  - V70.9
  - V71.7
  - V77.91

- V81.0-V81.2
- V82.9

## **Kidney Care Condition Management**

The Kidney Care Program is designed to improve self-management skills and promote adherence to treatment guidelines in order to reduce the risk of hospital admissions. This program has three focus areas including the following:

- Education to enhance understanding and compliance
- Nutrition counseling
- Tobacco cessation

A health coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Fluid and sodium restrictions as recommended by the treating physician
- Healthy nutrition and weight management counseling
- Blood pressure and cholesterol management
- Self-monitoring
- Break away from tobacco dependency with one-on-one support

The Kidney Care Conditions Management Program is offered via telephonic coaching and educational material (mailed and online). Members who choose to participate in telephonic coaching are considered “engaged” members and receive additional program incentives. The Kidney Care Program is managed by a registered nurse with a background in nephrology. The Kidney Care Conditions Manager meets with a board certified nephrologists on a weekly basis to review new members, develop and review plans of care, and review incoming laboratory results. When necessary, HMP’s nephrologist will make contact with treating providers to ensure the highest level of quality care.

### **Program Incentives:**

As an engaged member, your program incentives are determined by your risk stratification level.

### **Stratification Levels:**

#### **High Risk: Level 3**

- 2 telephonic coaching calls per month
- Educational materials when appropriate
- Up to 2 Clinic appointments with a board certified nephrologist
- Up to 2 Comprehensive Metabolic Panel with *Glomerular Filtration Rate (GFR)*
- Up to 2 Hemoglobin and Hematocrit levels
- Up to 2 Parathyroid hormone levels
- Up to 2 Lipid Panels
- Up to 2 Phosphorous (serum) level
- Up to 2 urine for albumin and creatinine ratio or protein and creatinine ratio
- Up to 2 Urinalysis
- 1 Ultrasound within 2 years of both kidneys, bladder, aorta and blood flow to the kidneys

#### **Medium Risk: Level 2**

- 1 telephonic coaching call per month
- Educational materials when appropriate

- 2 Up to Clinic appointments with a board certified nephrologist
- Up to 2 Comprehensive Metabolic Panel with *Glomerular Filtration Rate* (*GFR*)
- Up to 2 Hemoglobin and Hematocrit levels
- Up to 2 Parathyroid hormone levels
- Up to 2 Lipid Panels
- Up to 2 Phosphorous (serum) level
- Up to 2 Urinalysis
- Up to 2 Urines for albumin and creatinine ratio or protein and creatinine ratio
- Up to 1 Ultrasound within 2 years of both kidneys, bladder, aorta and blood flow to the kidneys

**Low Risk: Level 1**

- 4 telephonic coaching calls per year
- Educational materials when appropriate
- Up to 1 Clinic appointment with a board certified nephrologist
- Up to 1 Comprehensive Metabolic Panel with *Glomerular Filtration Rate* (*GFR*)
- Up to 1 Hemoglobin and Hematocrit level
- Up to 1 Urinalysis
- Up to 1 Urine for albumin and creatinine ratio or protein and creatinine ratio

**Stratification:**

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), knowledge of their diagnosis or condition, and readiness to change. The stratification level may change as member needs and clinical status changes.

**Program Incentive CPT Codes:**

The following will be paid at 100% when provided by an in-network provider per plan year:  
Nephrologist offices visit with blood pressure.

- Office visit must have one of the following-
  - 99201-99205
  - 99211-99215
  - 99241-99245
- Hemoglobin & Hematocrit
  - 85018 or 85014
- Comprehensive Metabolic Panel with GFR
  - 80053 and 82565
- Urine for albumin/creatinine ratio or protein/creatinine ratio
  - 82570 and 82043 or 82570 and 84156
- Urinalysis
  - 81001
- Parathyroid hormone
  - 83970

- Phosphorous (serum)
  - 84100
- Lipid Panel
  - 80061 or 83721 or 82465
- Ultrasound within 2 years both kidneys, bladder, aorta, and blood flow to the kidneys for Kidney Care disease
  - 76770 or 76775
- The diagnosis code below must be used.
  - 585.xxx
  - 584.xxx
  - 403.xxx
  - 404.xxx
  - V70.0

***ELIGIBLE PREVENTIVE CARE***

The Plan covers:

- Well Child Care
- Annual Wellness Exam
  - Women—a Well Woman preventive visit or gynecological exam visit in addition to the Annual Wellness Exam
- Cancer Screening Procedures
- Pregnancy Care Preventive Screenings
- Scheduled Immunizations and Vaccinations
- Review prescription section for additional preventive care items

Eligible Preventive Care is covered at 100% when the member meets age and frequency requirements. All three health plans cover eligible preventive care according to the following schedules. To be covered by the plan, Preventive Care services, including immunizations, must be received from a participating provider.

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.

***ELIGIBLE PREVENTIVE OFFICE VISIT SCHEDULE***

Age	Frequency
Birth to age 3 years*	<ul style="list-style-type: none"> <li>• 3 to 5 days old</li> <li>• 1 exam between birth and 2 months</li> <li>• 1 exam at 2 months</li> <li>• 1 exam at 4 months</li> <li>• 1 exam at 6 months</li> <li>• 1 exam at 9 months</li> <li>• 1 exam at 12 months</li> <li>• 1 exam at 15 months</li> <li>• 1 exam at 18 months</li> <li>• 1 exam at 24 months</li> <li>• 1 exam at 30 months</li> <li>• 1 exam at 3 years</li> </ul> See chart for specific services covered at exams.
4 -17 years**	1 exam per Plan Year See chart for specific services covered at exams.
18 years and up***	1 exam per Plan Year See chart for specific services covered at exams.
Pregnancy Preventive Screenings	See chart for specific services covered at exams.
Females under age 65– Well Woman or gynecological Exam	1 exam per Plan Year <ul style="list-style-type: none"> <li>• Office Visit</li> <li>• Pap Smear</li> <li>• Breast Exam by Physician</li> </ul> See chart for specific services covered at exam. This is in addition to Annual Wellness Exam. Pap smear is not required for this visit to be eligible.

**\*WELL CHILD CARE: Birth to 3 years**

Well Child Care Exam: Coverage provided for inpatient newborns; visits at 3 to 5 days old; and at or around 2, 4, 6, 9, 12, 15, 18, 24, 30 months, and 3 years.

Exams include: Health advice and information about development, behavior, safety/injury prevention, sleep positions, feeding, diet, daily care, physical activity and dental care. During the visit, the child may receive immunizations and screenings based on the healthcare practitioner’s recommendations. Immunization chart included in this document includes recommendations at time of publishing.

<b>Age</b>	<b>Frequency</b>
Weight, Height/Length, Blood Pressure and Head Circumference	At every visit as part of well child exam. Head circumference up to age 24 months.
Developmental Screening/Surveillance	At every visit as part of well child exam.
Autism	In-office screening with a standardized validated tool at 18 and 24 months. Maximum of two covered under well child care.
Vision	In-office medical screening as part of well child exam to detect amblyopia, strabismus, and defects in visual acuity. This is NOT a separate vision exam.
Hearing	In-office medical assessment as part of a well child exam. This is NOT a separate hearing exam.
Dental	Includes regular oral health screenings and referral to a dentist at the appropriate age. Healthcare practitioner may prescribe fluoride, if necessary, for a child over 6 months of age whose primary water source is deficient in fluoride. This is NOT a separate dental exam. See Pharmacy section for medication preventive coverage details
Hemoglobin or Hematocrit (Hgh/Hct)	One Hemoglobin or one Hematocrit between 9 and 15 months.
Lead Screening	One screening test at 12 months and one at 24 months.
Tuberculosis	Eligible as needed if screening questions are positive.

**\*\*WELL CHILD CARE: AGES 4 TO 17**

Well Child Care Exam: Once per plan year for children ages 4 to 17.

Exams include: Age and gender-appropriate health advice and information about dental care, exercise and physical activity, diet and nutrition, counseling for obesity (age 6 and over only), sun exposure and safety/injury prevention. When appropriate, alcohol, sexual behavior/sexually transmitted diseases (STDs), tobacco use and suicide prevention are also addressed. During the visit, the child may receive immunizations and screenings based on the healthcare practitioner's recommendation. Immunization chart included in this document includes recommendations at time of publishing.

\*\* Age 4-17 Childhood Healthcare reform guidelines at time of publishing are as follows:

<b>Guideline Title</b>	<b>Frequency</b>
Height/Weight/BMI/Blood Pressure	At every well child care exam. A review of Body Mass Index (BMI) may be completed by the healthcare practitioner to screen for obesity at age 6 and older.
Vision	In-office medical screening as part of well child care exam to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5. This is NOT a separate vision exam.
Hearing	In-office medical assessment as part of well child exam. This is NOT a separate hearing exam.
Dental	This includes regular oral health screenings and referral to a dentist at the appropriate age. Healthcare practitioner may prescribe fluoride, if necessary, for a child whose primary water source is deficient in fluoride. This is NOT a separate dental exam. See Pharmacy section for medication preventive coverage details
Sexually Transmitted Infections	All sexually active adolescents should be counseled and screened for STIs, including Chlamydia, gonorrhea, syphilis and HIV.
Cervical Dysplasia Screening	Annual pap smear for females at high risk at the discretion of the healthcare practitioner.
Tuberculosis	As needed if screening questions are positive.
Depression	Starting at age 12 for major depression when systems are in place to ensure accurate diagnosis, psychotherapy and follow-up.
Hemoglobin or Hematocrit Screening for anemia	Annually

**\*\*\*ANNUAL WELLNESS EXAM: 18 YEARS AND UP**

Annual Wellness Exam: Once per plan year for adults 18 years and up. Additionally, women are allowed a Well Woman or a gynecological exam annually while they are under 65.

Exams include: Health advice and counseling about dental care, exercise and physical activity, diet and nutrition, obesity, sun exposure, safety/injury prevention, domestic and interpersonal violence, alcohol, sexual behavior/sexually transmitted diseases (STDs) and tobacco use. During the visit member may receive immunizations and screenings based on the healthcare practitioner’s recommendation. Immunization chart included in this document includes recommendations at time of publishing.

**ANNUAL WELLNESS EXAM MEN AND WOMEN**

<b>Guideline Title</b>	<b>Frequency</b>
Height/Weight/Blood Pressure	At every Wellness Exam.
Cholesterol Test	<p><u>Men &amp; Women</u>:</p> <ul style="list-style-type: none"> <li>-Between the ages of 18 and 24 – one Lipid Profile.</li> </ul> <p><u>Men</u>:</p> <ul style="list-style-type: none"> <li>-Age 20-35 (at increased risk for coronary heart disease) – one Lipid Profile per plan year.</li> <li>-Age 35 and over – one Lipid Profile per plan year</li> </ul> <p><u>Women</u>:</p> <ul style="list-style-type: none"> <li>-Age 20 and older (at increased risk for coronary heart disease), one Lipid Profile per plan year.</li> </ul>
Counseling for Healthy Diet	In-office assessment and counseling for individuals with hyperlipidemia and other known risk factors for cardiovascular disease and diet-related chronic disease.
Diabetes	Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80.
Colorectal	<p>Ages 50 and older:</p> <ul style="list-style-type: none"> <li>–One fecal occult blood test per plan year.</li> <li>–Colonoscopy every 10 years or flexible sigmoidoscopy every 5 years.</li> <li>–1 Colonoscopy every 3 Plan Years beginning at age 50 for Members requiring more frequent follow up due to personal history /previous findings on a colonoscopy.</li> </ul> <p>See Pharmacy section for medication preventive coverage details.</p>
Sexually Transmitted Infections	High-intensity behavioral counseling to prevent STI’s. All adults at risk screened for STI’s including chlamydia (women), gonorrhea (women), syphilis and HIV.
Depression	Screen for major depression when systems are in place to ensure accurate diagnosis, effective treatment and follow-up.

### For Women Only

Guideline Title	Frequency
Breast Cancer - Mammograms	One baseline screening mammogram between ages 35 to 39 for women with a family history. One screening mammogram per plan year beginning at age 40.
BRCA	Women with a family history (breast or ovarian cancer) associated with increased risk for harmful mutations in BRCA1 or BRCA2 should be referred for genetic counseling and BRCA testing if appropriate. <b>(Limit: One per lifetime – Preauthorization Required)</b>
Counseling Women at High Risk for Breast Cancer	Counseling for chemoprevention of breast cancer as part of Annual Wellness Exam or Well Woman Exam.
Breast Cancer Risk-Reducing Medications	For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. See Pharmacy section for medication preventive coverage details
Cervical Cancer – Pap Smear	One screening pap smear per plan year.
HPV DNA Testing	High risk HPV DNA testing every three plan years for women with normal cytology results who are 30 or older.
Contraception	Prescription medications and devices that are approved by the Food and Drug Administration for treatment of and specifically prescribed for, contraception are available at zero-cost share to member. Note: Zero-cost share is not available for brand medications impacted by the “generics policy” (see page 72 of SPD for generics policy). See Pharmacy section for medication preventive coverage details
Sterilization Procedures	Food and drug administration-approved sterilization procedures, patient education and counseling. <b>Preauthorization Required</b>
Osteoporosis Screening	One per lifetime for women age 60 and older depending on risk factors.

### For Men Only

Guideline Title	Frequency
Prostate Specific Antigen (PSA)	An annual diagnostic exam, including a digital rectal examination and PSA test for asymptomatic men age 50 and older

**PREGNANCY CARE PREVENTIVE SCREENINGS**

The following are per pregnancy and are expected to be encompassed in the Pregnancy Preventive Health Visit. Only one office visit is covered at 100%. If screenings occur at another visit, only the screening will be covered at 100%. Pregnant members are encouraged to join the Our Healthy Baby Program as there are additional benefits available through the program.

<b>Guideline Title</b>	<b>Frequency</b>
Interventions to Support Breast-feeding	Interventions during pregnancy and after birth to promote and support breastfeeding.
Counseling for Tobacco Use	One screening per pregnancy for tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Screening for Anemia	One routine screening for iron deficiency anemia in asymptomatic pregnant women.
Screening for Bacteriuria	One screening per pregnancy for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Screening for chlamydial Infection	One screening per pregnancy for chlamydial infection for all pregnant women ages 24 and younger and for older pregnant women who are at increased risk.
Screening for hepatitis B	Screen for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
Screening for Rh incompatibility	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care and repeat between 24-28 weeks gestation unless the biological father is known to be Rh (D) - negative.
Screening for Syphilis	One screening per pregnancy for syphilis infection.
Screening for Gonorrhea	One screening per pregnancy for gonorrhea infection, if at high risk for infection.
Screening for HIV	One HIV screening per pregnancy.
Alcohol Screening	One screening per pregnancy for alcohol use and provide augmented pregnancy-tailored counseling to those who consume alcohol.
OB Panel	OB Blood Panel
Gestational Diabetes Screening	Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
Breast-feeding	<p>Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.</p> <p>Pump must be obtained within 60 days of delivery. Members will be reimbursed up to \$150 for a manual breast pump and up to \$220 for an electric breast pump.</p> <p>Limited to one manual pump every 12 months OR one electric pump every 3 plan years. Replacement pumps are covered for subsequent pregnancies for members who have not received a pump within the timeframes outlined above.</p>

## ***OUR HEALTHY BABY PROGRAM***

The Our Healthy Baby™ Program is a voluntary program available to expectant mothers covered by the South Dakota State Employee Health Plan.

The purpose of this program is to provide support to expectant parents through individual case management, educational materials, and contact throughout the Pregnancy. By providing this service, the South Dakota State Employee Health Plan achieves healthier outcomes for Members.

### **Program incentives include:**

- Expectant mothers covered under the Plan who enroll in the program within the first three months of Pregnancy receive a **\$250 non-tax incentive** into their Health Reward and Wellness Account;
- Choice of one available prenatal or parenting book upon enrollment;
- One first trimester ultrasound to confirm viable pregnancy covered at 100% (Pre-authorized by HMP);
- One second trimester ultrasound to verify dates and growth covered at 100% (Pre-authorized by HMP);
- Online access to Pregnancy related information;
- Educational materials mailed to Members throughout the Pregnancy;
- Expectant mothers covered under the Plan who complete the program receive an additional **\$250 non-tax incentive** into their Health Reward and Wellness Account upon successful participation and completion of program; and
- Follow-up after the Pregnancy.

***Enrollment in the Our Healthy Baby™ Program does not automatically add the new child to the Health Plan.***

To be covered, the child must be enrolled in the Plan within 60 days of the birth. The Employee must complete a Family Status Change form during the 60 day time period and pay required contributions for coverage to take effect. The child of a Dependent cannot be added to the health plan.

If the child is not added during the 60-day Special Enrollment Period, the child will not be covered under the Plan. The Employee will be able to enroll the child during Annual Enrollment or when incurring qualifying family status change or after satisfying a waiting period. See “Special Enrollment” and “Late Entrants to the South Dakota State Employee Health Plan” sections.

For more information contact Health Management Partners (HMP), at 888.330.9886 or by enrolling online at <https://sosd.hmpsportal.com>. Log in to the portal then choose Our Healthy Baby under Programs.

**SCHEDULED IMMUNIZATIONS AND VACCINATIONS**

Scheduled immunizations and vaccinations are available under all health three plans, covered at 100%, when incurred with a participating network provider.

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Immunizations and Vaccinations as listed below are covered 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.

The following immunizations are covered at 100% when services are provided by a participating provider.

Treatment	Frequency
Hepatitis A Vaccine	At 12-23 months
Hepatitis B Vaccine	At birth, plus 2 between birth and 18 months
Rotavirus	At 2, 4, and 6 months
DTaP Vaccine	At 2, 4, 6, and 15-18 months
DTaP Booster	Once between 4 and 6 years
IPV Vaccine	At 2, 4, and 6-18 months
IPV Booster	Once between 4 and 6 years
MMR Vaccine	At 12-15 months and 2nd dose 4-6 years
HIB Vaccine	At 2, 4, and 6 months plus 1 booster at 12-15 months
Varicella Vaccine	At 12-15 months and 1 dose between 4 and 6 years; 2 doses for adults 19-65 years
Pneumococcal Conjugate Vaccine (PCV or Prevnar) a vaccine to prevent pneumonia	At 2, 4, 6, and 12-15 months
Pneumovax	Allowed with documented risk factors for ages 19 to 65 years, all adults 65 and older
Tdap	Once at 11-12 years of age, and every 10 years for adults
Tetanus/Diphtheria Booster	Every 10 years for adults
HPV	11-26 years, 3 dose series
Meningitis, Meningococcal Conjugate Vaccine	Age 11-12, and 1 booster at age 16.
Influenza Vaccine	<p>1 to 2 doses between age 6 months through age 6 and once each Plan Year thereafter.</p> <p>The State offers all covered members flu shots at State sponsored clinics each year, beginning in October. Refer to <a href="http://benefits.sd.gov">http://benefits.sd.gov</a> for times and locations.</p> <p>The plan will only pay for the cost of the vaccine and the administration fee for members who choose to receive influenza vaccine somewhere other than a State sponsored clinic.</p> <p>Vaccines received at the pharmacy must be CVS Caremark participating pharmacy, and submitted through the pharmacy program.</p> <p>Vaccines received at a medical provider, must be received at a participating provider.</p>
Zoster (Shingle)	1 dose for adults age 60 and older

Sources: Department of Health and Human Services, Center for Disease Control and Prevention, and South Dakota Department of Health.

- If a combination vaccine is received, the Member must be eligible to receive at least one of the vaccines included in the combination vaccine to be covered.
- Vaccinations required for employment and travel are not eligible.

### ***LATITUDE EMPLOYEE ASSISTANCE PROGRAM (LEAP)***

LEAP helps employees resolve a wide range of issues and restore both personal and professional effectiveness. LEAP will assist employees in managing the personal challenges that influence well-being, performance, and effectiveness. Employees using LEAP services must follow established leave policies; contact your Human Resource Manager with questions.

#### **LEAP Eligibility**

LEAP is available to benefit eligible state employees, Spouses and Dependents. State employees, Spouses and Dependents do not need to be covered under the South Dakota State Employee Health Plan to use LEAP services. Visit [www.apshelplink.com](http://www.apshelplink.com) and enter company code southdakota to learn more or call 800.713.6288.

#### **Covered Services:**

- Stress/Anxiety
- Financial/Legal Concerns
- Managing Change & Transition
- Drug/Alcohol
- Work Related Concerns
- Family/Relationship Issues
- Grief
- Depression
- Parenting Issues
- Child/Eldercare Issues
- Management or Supervisory Issues

#### **Program Incentives:**

- Telephonic support by Masters and PhD level counselors for crises and emergencies
- Telephonic support to arrange for in-person counseling
- Up to 5 in-person counseling sessions (per incident per fiscal year) for a range of personal issues, depression, work-family balance, and substance abuse concerns. Employees must have a referral from APS to use counseling services.

#### **Consultation Services:**

In addition, LEAP offers consultations including:

- **Family Caregiving** - Resources and referrals for dependent care related services, in addition to emergency back-up childcare and elder and more.
- **Convenience Services** - Assistance in locating household and daily living resources, including pet care services, home repairs, travel planning and event scheduling and more.
- **Financial Services** - Up to 30-minutes financial consultation with a Certified Financial Planner or CPA per issue at no-cost.
- **Legal Services** - Up to 30-minutes consultation per issue with an attorney at no-cost and 25% discount of fees if you decide to retain an attorney.