PMB 0141-1
500 East Capitol Ave
Pierre, SD 57501-5070
Phone: 605.773.3148 or 877.573.7347, option 2
Fax: 605.773.6840

SOUTH DAKOTA
state employee
benefits program
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FY19 Enrollment Factsheet

Name _____

_____
Address City State Zip Code

Social Security Number_____Birth Date_____Gender _____

Date of Hire _____Employee #_____

As a new employee, one of the first things you'll want to do is select benefits for yourself and your eligible spouse and dependent(s). Before you enroll, read through the enrollment material at **http://benefits.sd.gov** for more detailed information about benefit choices and plan features. Mark your FY19 elections on this Factsheet to use as a guide when enrolling online.

If you do not make benefit elections within 30 days of hire:

- You will be given the default coverage (High Deductible Health Plan), with no spouse or dependent coverage.
- You will not be eligible for Flexible Benefits until Annual Enrollment.
- You will not be able to make benefit elections for yourself and/or any eligible spouse or dependent(s) without a qualified family status change (i.e. birth, pending birth, adoption, marriage, etc) or until the next Annual Enrollment.

To enroll visit http://benefits.sd.gov

- Click on **Active Employee**
- Scroll over **Enroll**
- Click on **New Employee**
- Click on **Click Here to Enroll**
- Click on the **Register** button
- Enter an email address, username, and password. Re-enter the password.
- Click the check box next to the text, "I'm not a robot." (A popup of image tiles will appear. Follow the instructions in the popup.)
- Click on the **Register** button
- An email will be sent to the address you entered
- Open the confirmation email sent to your account and click the link it contains
- You will be redirected to the Log in screen
- Log in by entering the user name and password you provided earlier
- Click the check box next to the text, "I'm not a robot." (A popup of image tiles will appear. Follow the instructions in the popup.)
- Click the **Log in** button

Eligible Spouse and Dependent Information
You must provide the following information about any eligible spouse or dependents you wish to enroll. To make the process easier, write that information below and refer to it during your enrollment. List only a spouse and/or dependents you want to cover in FY19. The plans to the far right of the sheet indicate benefit choices you can make for your spouse and each dependent. Please note: The relationship codes are self, spouse, and child.

Name	SSN	Birthday	Gender	Relationship	Health/Dental/Vision/Accident/Hospital
				Self	

Refer to your Summary Plan Description Document for details about eligible spouse and dependents, initial and special enrollment periods, and definition of late entrants.

Health Plan

Plan Options:

- ☐ **Opt-Out* (no coverage)**
- ☐ **Low Deductible Health Plan ($1,000)**
- ☐ **High Deductible Health Plan ($2,000/$4,000) with Health Savings Account (HSA)**

Coverage Levels: (visit **http://benefits.sd.gov** for contribution rates)

- ☐ **Employee only**
- ☐ **Employee + one child**
- ☐ **Employee + two children**
- ☐ **Employee + three or more children**
- ☐ **Employee + spouse**
- ☐ **Employee + spouse + one child**
- ☐ **Employee + spouse + two or more children**

*If you elect to Opt-Out of the Health Plan, you must provide proof of credible coverage from another group health plan by providing satisfactory written evidence to the Bureau of Human Resources. You are also eligible to receive an Opt Out credit of $300. Please refer to the Summary Plan Description Document at **http://benefits.sd.gov** for more information.

Tobacco User Status

- ☐ **Neither my covered spouse nor I use a tobacco product**
- ☐ **Only I use a tobacco product**
- ☐ **Only my covered spouse uses a tobacco product**
- ☐ **My covered spouse and I both use a tobacco product**

Coordination of Benefits

Are you (the employee) covered for health care coverage under another group health plan or Medicare?

- ☐ **Yes**
- ☐ **No**

If your spouse or any of your dependents are covered under the South Dakota State Employee Health Plan, are they also covered for health care coverage under another group health plan or medicare?

- ☐ **Yes**
- ☐ **No**

Dependent Care/Day Care Spending Account

Based on your tax filing status, the IRS maximum you can contribute for calendar year 2018 is $5,000 per household. See your Summary Plan Description Document for rules that may affect contribution amounts. The amount you enter below is per pay period.

Options:

- ☐ **No participation**
- ☐ **Participate and contribute $_____.____per pay period**

Medical Flexible Spending Account (FSA)

The IRS annual maximum deposit to the Medical Flexible Spending Account is $2,650 for 2018 calendar year. The amount you enter below is per pay period. This will be a Combination FSA if you select the High Deductible Health Plan, HSA, and FSA.

Options:

- ☐ **No participation**
- ☐ **Participate and contribute $_____.____per pay period**

Health Savings Account (only with High Deductible Health Plan)

The IRS annual maximum contribution for calendar year 2018 to an Health Saving Account is $3,450 for an individual and $6,850 for a family for 2018 calendar year (this includes both the State's contribution plus any contributions you choose to make). The amount you enter below is per pay period.

Options:

- ☐ **I am not eligible**
- ☐ **I prefer not to have an HSA and will forfeit my State HSA contribution**
- ☐ **I want an HSA with no payroll contributions**
- ☐ **I want an HSA and will contribute the following amount each pay period $____.____**

Dental Plan

Base Plan Coverage Levels:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **Employee only**	$ 16.20	$ 32.40
☐ **Employee + Spouse**	$ 32.35	$ 64.70
☐ **Employee + Child(ren)**	$ 35.41	$ 70.82
☐ **Employee + Family**	$ 51.56	$ 103.12

Enhanced Plan Coverage Levels:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **Employee only**	$ 26.17	$ 52.34
☐ **Employee + Spouse**	$ 52.25	$ 104.50
☐ **Employee + Child(ren)**	$ 53.28	$ 106.56
☐ **Employee + Family**	$ 79.37	$ 158.74

Vision Plan

Coverage Levels:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **Employee only**	$ 3.54	$ 7.08
☐ **Employee + Spouse**	$ 7.09	$ 14.18
☐ **Employee + Child(ren)**	$ 6.00	$ 12.00
☐ **Employee + Family**	$ 9.90	$ 19.80

Accident Insurance Plan

Coverage Levels:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **Employee only**	$ 2.28	$ 4.56
☐ **Employee + Spouse**	$ 4.37	$ 8.74
☐ **Employee + Child(ren)**	$ 4.85	$ 9.70
☐ **Employee + Family**	$ 6.08	$ 12.16

Hospital Indemnity Insurance

Coverage Levels:	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **Employee only**	$ 4.19	$ 8.38
☐ **Employee + Spouse**	$ 6.65	$ 13.30
☐ **Employee + Child(ren)**	$ 8.66	$ 17.32
☐ **Employee + Family**	$ 11.20	$ 22.40

Short-Term Disability Income Protection Plan

Coverage Level	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
□ **No coverage**	$0.00	$0.00
□ **Employee only**	$0.127 per $10 weekly benefit up to $1,200.	$0.254 per $10 weekly Benefit up to $1,200.

How to calculate your contribution amount:

A. Hourly Rate =	$
B. Annual Earnings = (A x 2088)	$
C. Weekly Earnings = (B ÷ 52)	$
D. Weekly Benefit = (C x 0.6)	$
E. Value Per $10 = (D ÷ 10)	$
F. Estimated Monthly Contribution = *(E x by 0.254)	$

*If you are paid two times per month, you would multiply by 0.127 to get your semi-monthly contribution.

Enter your CONFIRMATION NUMBER for your records _____

Life Enrollment

The South Dakota State Employee Health Plan provides you with Basic Life Coverage through MetLife in the amount of $25,000. You may also elect additional Supplemental Life Coverage and Dependent Life Coverage.

Employee Supplemental Life Insurance

Options:

- ☐ **No coverage**
- ☐ **1 x annual salary**
- ☐ **2 x annual salary**
- ☐ **3 x annual salary**
- ☐ **4 x annual salary**
- ☐ **5 x annual salary**
- ☐ **6 x annual salary**
- ☐ **7 x annual salary**

You may choose supplemental life coverage levels of one, two, three, four, five, six, or seven times annual salary up to $1,000,000 through MetLife.

If you are applying for six or seven times your salary coverage, or over $400,000, or an increase to your current amount, outside of your 30-day new hire enrollment period, you need to go through an approval process.

The MetLife supplemental life insurance plan is portable, meaning you may be able to continue the policy on your own when you end employment with the State up to age 99.

PREMIUM RATE PER $1000 OF COVERAGE PER PAY PERIOD

AGE GROUP	24 Pay Periods	12 Pay Periods
<30	$0.035	$0.070
30 to 34	$0.042	$0.084
35 to 39	$0.049	$0.098
40 to 44	$0.057	$0.114
45 to 49	$0.075	$0.150
50 to 54	$0.104	$0.208
55 to 59	$0.155	$0.310
60 to 64	$0.225	$0.450
65 to 69	$0.414	$0.828
70+	$0.666	$1.332

Employee Accidental Death & Dismemberment (AD&D)

The AD&D coverage provides an additional benefit in the case of accidental death and dismemberment. AD&D must equal the Supplemental Life Coverage.

Options:

- ☐ **Yes, I want AD&D.**
- ☐ **No**, **I don't want AD&D.**
- ☐ **N/A**

PREMIUMS PER $1,000 OF COVERAGE PER PAY PERIOD

24 Pay Periods	12 Pay Periods
$0.01	$0.02

Employee Accidental Death & Dismemberment (AD&D)

The AD&D coverage provides an additional benefit in the case of accidental death and dismemberment. AD&D must equal the Supplemental Life Coverage.

	PREMIUMS PER $1,000 OF COVERAGE PER PAY PERIOD	
Options:	24 Pay Periods	12 Pay Periods
☐ **Yes, I want AD&D.**	$0.01	$0.02
☐ **No, I don't want AD&D.**		
☐ **N/A**		

Spouse & Dependent Life Insurance

Employees who are covered under Supplemental Life coverage may elect $10,000 Spouse & Dependent Life Coverage. The cost is the same regardless of the number of eligible dependents. If Employee AD&D is elected, it will also apply to Spouse & Dependent Life Coverage. The contribution rate for 24 pay periods is $0.15 and for 12 pay periods $0.30.

	Premiums Per Pay Period	
Options:	24 Pay Periods	12 Pay Periods
☐ **No coverage**	$ 0.00	$ 0.00
☐ **$10,000 Life coverage**	$ 0.96	$ 1.92
☐ **$10,000 AD&D coverage**	$ 0.15	$ 0.30

Life Insurance Beneficiary(ies)

Enter the beneficiary(ies) first name, last name, address, relationship (i.e. spouse, child or other), and share to each beneficiary.

Primary Beneficiary(ies)

First Name/Last Name	Address	Relationship	Share to each

Contingent Beneficiary(ies)

First Name/Last Name	Address	Relationship	Share to each