PMB 0141-1
3800 E. Highway 34, Suite 1
Pierre, SD 57501
605.773.3148
benefitswebsite@state.sd.us

FY21 Enrollment Factsheet

Name:_____

_____
Address City State Zip Code

SSN:_____ 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://bhr.sd.gov/benefits/ for more detailed information about benefit choices and plan features. Mark your FY21 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 https://bhr.sd.gov/benefits/

- Click on **Active Employee**
- Scroll over **Enroll**
- Click 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.)
- Click 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 inside
- You will be redirected to the Log in screen
- Log in by entering the username 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.)
- 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 FY21. 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	DOB	Gender	Relationship	Health/Dental/Vision/Accident/Hospital

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

It is important to note that if you are adding a spouse and/or dependents for the first time, you will receive a dependent verification form from our partner, Dialog Direct. Failure to provide the requested documentation will result in your spouse and/or dependents being removed from coverage. If this occurs, you will not be able to re-enroll them unless you experience a qualified life event or until the next Annual Enrollment period.

Health Plan

Plan Options

- ☐ **Opt-Out* (No coverage)**
- ☐ **Opt-Out to Medicare (No coverage)**
- ☐ **Low Deductible Health Plan ($1,500)**
- ☐ **High Deductible Health Plan ($2,200 | $4,400) with Health Savings Account (HSA)**

Coverage Levels: (Visit https://bhr.sd.gov/benefits/ 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**

*You can Opt-Out of the Health Plan if you provide proof of other credible group health coverage, TRICARE, or Medicare. Please note Medicaid, Indian Health Services, or VA coverage are NOT considered creditable group health coverage. If you Opt-Out due to other group health coverage or Tricare, you will receive $300 in a Combination Health Reimbursement Account (HRA) at Discovery Benefits. However, due to regulations, the State is prohibited from contributing to an HRA account if you Opt-Out due to Medicare coverage. Please refer to the Summary Plan Description Document at **http://bhr.sd.gov/benefits/** or the FY21 Decision Guide at **https://bhr.sd.gov/benefits/FY21Files/FY21DecisionGuide.pdf** 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 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 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 2020 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

The IRS annual maximum deposit to the Medical Flexible Spending Account is $2,750 for the 2020 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 2020 to a Health Saving Account is $3,550 for an individual and $7,100 for a family (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** (Please see page 15 of the **FY21 Decision Guide** for reasons you may be ineligible)
- ☐ **I am choosing not to have an HSA and I understand that I will not receive the State contribution.**
- ☐ **I want an State contribution (if qualified) to my HSA, but I will not add my own pre-tax money to my HSA at this time.**

☐ **I want the State contribution (if qualified) to my HSA, and I would like to add my own pre-tax money to my HSA at a pay period amount of $_____.**

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	$52.32
☐ **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**	$0.1455 per $10 weekly benefit up to $1,200.	$0.291 per $10 weekly benefit up to $1,200.

How to calculate employee contribution premium:

24 Pay Periods - Full-Time Employee

A.	Rate of Pay = • (for Hourly Employees is your Hourly Rate) • (for Salaried Employees is your Annual Salary)	$16.50 $34,452.00
B.	Annual Earnings = • (for Hourly Employees is A x 2088 annual hours) • (for Salaried Employees is A)	$34,452.00 $34,452.00
C.	• Short-Term Disability Benefit = (B x 0.7)	$24,116.40
D.	Weekly Benefit = (C / 52)	$463.78
E.	Value Per $10 = (D / 10)	$46.38
F.	Estimated Pay Period Premium Rate = (E x 0.1455)	$6.75

12 Pay Periods - Full-Time Employee

A.	Rate of Pay = • (for Hourly Employees is your Hourly Rate) • (for Salaried Employees is your Annual Salary)	$16.50 $34,452.00
B.	Annual Earnings = • (for Hourly Employees is A x 2088 annual hours) • (for Salaried Employees is A)	$34,452.00 $34,452.00
C.	• Short-Term Disability Benefit = (B x 0.7)	$24,116.40
D.	Weekly Benefit = (C / 52)	$463.78
E.	Value Per $10 = (D / 10)	$46.38
F.	Estimated Pay Period Premium Rate = (E x 0.291)	$13.50

Visit https://bhr.sd.gov/benefits/active/flexible-benefits/short-term-disability/ for part-time rates.

Enter your CONFIRMATION NUMBER for your records:_____
(Note: Fill this section in if you enroll electronically.**)**

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**

PREMIUM RATE PER $1,000 of COVERARE PER PAY PERIOD

AGE	24 Pay	12 Pay
<30	$0.035	$0.070
30 to 34	$0.042	$0.084
35 to 39	$0.049	$0.098
40 to 44	$0.057	$0.113
45 to 49	$0.075	$0.150
50 to 54	$0.104	$0.208
55 to 59	$0.155	$0.310
60 to 64	$0.255	$0.450
65 to 69	$0.414	$0.828
70+	$0.666	$1.332

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.

If you have additional questions about Supplemental Life, please see page 27 of the FY21 Decision Guide.

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**

PREMIUM RATE PER $1,000 of COVERARE PER PAY PERIOD	
24 Pay Periods	12 Pay Periods
$0.01	$0.02

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.

Options:

	Premiums Per Pay Period	
	24 Pay Periods	12 Pay Periods
☐ **No Coverage**	$0.00	$0.00
☐ **$10,00 Life coverage**	$0.96	$1.92
☐ **$10,00 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**

Approval for Additional Payroll Deductions

I authorize the State of South Dakota Benefits Program to take an additional deduction from my pay (if necessary) for myself and my family member(s) to be effective one month and one day from my date of hire. By choosing No, I realize that the coverage effective date is based on the first payroll deduction date.

- ☐ **Yes,** I authorize additional premium charges to my payroll in order to begin elected coverage one month and one day from my date of hire.

- ☐ **No,** I understand the elected coverage is effective based on the first payroll deduction date.

By signing, I authorize the State of South Dakota Benefits Program to enroll me for the benefits I have indicated above. I also authorize the State of South Dakota to deduct, from each paycheck, the premiums for the benefits which I selected below.

Signature _____ Date _____