Welcome

Welcome to the online benefits orientation.

Benefits start 1 month and 1 day from your hire date. You need to enroll in benefits within 30 calendar days of your date of hire. If you do not enroll or opt-out within 30 calendar days from your date of hire, you will automatically be enrolled in the middle deductible plan with no options to add dependents and/or flexible benefits to your plan. Our benefits plan year runs from July 1\textsuperscript{st} to June 30\textsuperscript{th}.

If you want to make changes to your benefit elections, after the initial 30 days, you will need to wait until the annual enrollment period. Annual enrollment usually takes place during the first 2 weeks of May for the upcoming plan year. Changes to your benefit plan can also be made if you have a qualifying family status change. These qualifying events will be discussed later on in the presentation. For additional information about our benefits please refer to the decision guide located on the Benefits website. This guide will be helpful to ensure you are making the most informed decision before enrolling in your benefits.

To begin, we are going to discuss your options regarding health insurance. We are insured by the South Dakota Employee Benefits program. We use DakotaCare to process claims and for their network of providers. First we will discuss the different deductible plans. There are 3 different deductible plans to choose from when selecting your health plan. A deductible is how much you have to pay out of your pocket before the insurance will “kick in”. We will also talk about prescription drug coverage. Prescription drug coverage varies depending on the deductible plan you choose. Later in the presentation we will discuss the Tier 1 program. Tier 1 is a benefit that will reduce the cost associated with certain services. And lastly, if you have other coverage, you have the option to opt out of our health insurance.

Health Insurance

The first health plan we are going to discuss is the $750 deductible plan which is the lowest deductible plan. In order to be eligible for the lowest deductible plan there are 3 requirements you and your covered spouse will have to complete. These requirements consist of a Health Screening, a Health Assessment, and a Latitude Wellness Program. If you were hired after July 1\textsuperscript{st} of this year, you do not need to complete these requirements, but you may do so if you wish. For the following fiscal year you and your covered spouse will need to complete these requirements to stay eligible for the lowest deductible plan. Please watch your email and benefits newsletters for the designated completion deadlines for the 3 requirements. You must meet a $750 per person deductible or a $1,875 family deductible if you have coverage for a family of 3 or more. After the deductible has been met, when using a Dakotacare network provider, a 25% coinsurance applies until the out-of-pocket maximum has been met. With the lowest deductible plan there is a separate prescription drug deductible of $50 per person, per plan year, before the prescription drug coverage begins. There is also a $250 copayment for emergency room visits.

The next health plan is the $1,250 deductible plan. There are no requirements to be eligible for this plan. You must meet a $1,250 per person deductible or a $3,125 family deductible if you have coverage for a family of 3 or more. After the deductible has been met, when using a Dakotacare network provider, a 25% coinsurance applies until the out-of-pocket maximum has been met. Just like the lowest deductible plan, the $1,250 deductible plan has a separate prescription drug deductible of $50 per person, per plan year, before the prescription drug coverage begins. There is also a $250 copayment for emergency room visits.

For the highest deductible plan there is a $1,800 deductible for single coverage or a $3,600 deductible for family coverage. The family deductible must be met by 1 or more individuals before any benefits will be paid. The highest deductible plan also includes a health savings account or HSA. A Health Savings Account enables you to pay for covered medical expenses with pretax dollars. If you open a Health Savings Account and complete the Health...
Savings Account form, you will receive a $300 employer contribution from the State. For a list of frequently asked questions and additional information about the Health Savings Account please go to the benefits website. There are no requirements to be eligible for the highest deductible plan. There is also no prescription drug plan with this deductible. Members pay for prescription drug expenses, which apply to the health deductible until the deductible has been met. With the highest deductible plan there is no copayment for emergency room visits.

The Health Plan Comparison Chart shows the 3 different deductible plans and their coverage details. Within each deductible plan, the chart compares the benefits of using a Network Provider versus an Out-of-Network Provider. Insurance pays more when you use a Network Provider, but you may choose any provider of your choice. Also shown on the chart is coinsurance. Coinsurance is a percentage amount that is paid by both the insurance and you for expenses you incur after meeting your deductible. This chart is taken directly from the Decision Guide located on the benefits website.

The chart on this slide and the following slide compares the health plan premiums for the 3 different plans. No matter which deductible plan you choose the department pays for your health insurance. Health insurance is free for you, however if you add dependents you will pay a monthly premium. This chart can be used to determine how much it will cost you each pay period if you elect to add dependents. These contributions are deducted on a pretax basis. When determining the premium for a spouse you need to use their age as of July 1st.

The chart on this slide shows the monthly premiums for each deductible plan when adding a spouse and a child or children to your health plan. Please note at the bottom of the chart: There is also a $60 per person, per pay period premium that will be added to your monthly deductions if you and/or your covered spouse use tobacco products. So that means if you and your covered spouse both use tobacco products there will be an additional $120 per pay period deducted from your paycheck. The premiums deducted from your paycheck pay for the upcoming month’s coverage. For example the premiums you pay in October are used to cover November insurance.

Prescription Drug Coverage

Prescription drug coverage is provided by CVS Caremark. If you elect the $750 or $1,250 deductible plans, there is a $50 deductible per person, per plan year for prescription drug coverage. 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. If you elect the highest deductible plan you are responsible for paying the full amount for any prescriptions. However, this payment will go towards the overall health insurance deductible amount.

This chart shows the prescription drug coverage under the two lowest deductible plans. For additional information about pharmacies and prescriptions please view the pharmacy section located on the benefits website.

Tier 1

The next thing we are going to talk about is Tier 1. Tier 1 is a benefit that will reduce the cost associated with certain services. Tier 1 does not apply to eligible preventive care. To be covered under Tier 1 the service has to be billed as medical, not preventive. If you have a Tier 1 service, at a Tier 1 facility, by an approved Tier 1 provider, you will have a lower out-of-pocket maximum. The out-of-pocket maximum is the most you will pay for services during a fiscal year. Tier 1 services require pre-authorization by Health Management Partners (HMP) regardless of the provider or facility.

This chart shows some of the Tier 1 services. To see a complete list of Tier 1 facilities, services, providers and frequently asked questions please refer to the benefits website.

Pre-Authorization

In some cases, Health Management Partners or HMP must pre-authorize services or referrals. To view the Pre-authorized listings visit the benefits website. Scroll over Forms/Documents and click Forms/Documents. The Pre-
authorization listing is in the other section. For example, Tier 1 services require pre-authorization by Health Management Partners. For additional information please contact Health Management Partners.

**Preventive Care**

Eligible preventive services are covered prior to satisfying your deductible. Eligible preventive care is covered at 100% when the member meets age and frequency requirements. To view the eligible preventive care services, please visit the benefits website.

**Opt Out**

If you would like to opt out of the health insurance you must provide proof of creditable coverage. Acceptable proof of coverage includes a certificate of coverage that indicates active coverage. Proof is required each fiscal year you elect to opt out. Once you have provided proof of other coverage, you will receive a $300 opt out credit. This $300 credit is deposited into an account at Dakota Care. If you do not use the full amount it can be carried over from one year to the next.

**Additional Information**

For additional information about benefits please view the Decision Guide on the benefits website. If you have specific questions regarding the health plans or your coverage please contact Dakotacare.

**Flexible Benefits**

The South Dakota State Employee Benefits Program offers voluntary Flexible Benefit Plans. These Benefits include: Dental, Vision, Accident, Hospital Indemnity, and Short Term Disability. In order to enroll dependents on the Flexible benefit, you must elect the benefit for yourself. You may choose which dependents to cover under these plans. Flexible Benefit enrollment is available even if you opt out of the State Health Insurance. Let’s take a closer look at the individual Flexible Benefits.

**Dental**

The first flexible benefit we will discuss is Dental Insurance. There are 2 Dental Plans to choose from: the Base Plan or the Enhanced Plan. Both of these plans are provided by Delta Dental. Delta Dental has an expanded network that includes 98% of the dentists in South Dakota. There is a $25 per plan year, per member deductible. Both plans pay for services based on a percentage of allowable charges. Under both plans the member is responsible for the deductible, charges that exceed the covered percentage of allowable charges and any charges over the annual maximum. The annual maximum for the base plan is $1,000 and the annual maximum for the enhanced plan is $1,500.

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 the Delta Dental website and click on Find a Dentist. If you enroll in either dental plan for FY16, there are NO waiting periods for major and orthodontic services. Additional dental plan information is available at Benefits website. You may also call Delta Dental with any questions at the number listed. Let’s take a closer look at the Dental Plan.

This chart provides an overview of the Dental insurance and compares the two plans that you can choose from. You will notice that members enrolled in the enhanced plan have a Maximum Bonus Account. The Maximum Bonus Account is a savings account available to members enrolled in the Enhanced Plan. These members 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 the benefits paid are less than $750 for the plan year. The MBA maximum is $1,500 per member and cannot be used on orthodontic claims.

Now let’s take a look the different types of services and the covered percentages for those services. This chart shows the Diagnostic & Preventive services, the frequency you can receive those services and the covered percentages based on the dental plan. The base plan covers all services shown at 75% and the enhanced plan covers all services shown at 100%.

Routine and Restorative services are covered based on a percentage of allowable charges. This chart shows the routine and restorative services, the frequency that you can receive those services, and covered percentages based on the dental plan. The Base plan covers all services shown at 60% and the enhanced plan covers all services shown at 80%.

Major services are also covered based on a percentage of allowable charges. This chart shows the major services, the frequency you can receive those services, and covered percentages based on the dental plan. The Base plan covers all services shown at 35% and the enhanced plan covers all services shown at 50%. Remember members who do not enroll when initially eligible, will have a 1 year waiting period for Major and Orthodontic services. The waiting period does not apply to new hires or members added with a valid family status change. Both plans cover orthodontics. The base plan has a $1,000 lifetime benefit for orthodontics and only covers dependent children up to the age of 19 for orthodontics. The enhanced plan has a $1,500 lifetime benefit for orthodontics and covers both adults and dependent children for orthodontics.

Here are the premiums for both the Base and Enhanced plans. You will notice there is a new rate structure. You can elect coverage for employee, employee plus spouse, employee plus child or children, and employee plus family. Premiums for coverage under the dental plan are made on a pretax basis.

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. These health conditions are: Gum periodontal disease, Diabetes, Pregnancy, Kidney failure or undergoing dialysis, Undergoing cancer-related chemotherapy and/or radiation, Suppressed immune systems, and At risk for oral cancer. Please refer to the Decision Guide on the Benefits website for a description of the additional benefits offered through this program.

Additional plan information and examples of both plans can be found at the Benefits website. If you have any questions about the dental plans, you may also call Delta Dental at the number listed.

**Vision**

The second flexible benefit we will review is the stand alone Vision Plan that is provided by MetLife. The Vision plan covers a wide range of services such as eye exams, glasses and contact fittings. To find an In-Network provider visit the MetLife website and click on Find a Vision Provider, then enter in a zip code, and select Metlife Vision PPO as the plan. 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. For example, the cost of an eye exam is $150.00. At an In-Network provider, your responsibility is the $10 copay. At an Out-of-Network provider, you pay the provider at the time of service and are reimbursed up to $45.00 by MetLife after you submit a claim form.

This chart describes the vision services, the insurance coverage for those services and the frequency you can receive those services. The vision plan covers either glasses or contact lenses every 12 months. Services covered under the vision plan are based on the date of service, not plan year.

This chart is a continuation of the services you can receive under the vision plan. Please contact MetLife at the number listed for any questions regarding vision services.
Here are the premiums for the Vision Plan. You can elect coverage for employee, employee plus spouse, employee plus child or children, and employee plus family. Premiums for coverage under the vision plan are made on a pretax basis.

**Accident Insurance Plan**

Another flexible benefit option is the Accident Insurance Plan. This plan was formerly known as Major Injury Protection Plan. This benefit is now provided by MetLife. Accident Insurance provides you with a lump-sum payment when you suffer a covered injury or undergo covered testing, medical services or treatment and meet the group policy and certificate requirements. There are more than 150 covered events and there is no limit on the number of different accidents that will be covered. You can use the Accident Insurance Plan benefit for any purpose you like, for example: to help pay for expenses not covered by your medical plan, deductible, coinsurance, or your out-of-pocket maximum. Payments will be made directly to you to use as you see fit. To view covered benefits, visit the Benefits website.

There are no waiting periods for coverage and payments are made in addition to any other insurance you may have. This chart shows the premiums for the Accident Insurance plan. Premiums are made on an after tax basis. You can elect coverage for employee, employee plus spouse, employee plus child or children, and employee plus family. The Accident Insurance Plan is portable meaning you can continue your coverage if your employment status with the State changes. If you have any questions regarding the Accident Insurance Plan, please call MetLife at the number listed.

**Hospital Indemnity Plan**

The next flexible benefit is the Hospital Indemnity plan, which is provided by VOYA Financial and Risty Benefits. There are no medical questions required to enroll. There are also no waiting periods for coverage and payments are made in addition to any other insurance you may have. There is no pre-existing exclusion limitation. You can use the Hospital Indemnity Plan benefit for any purpose you like, for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care cost, or any of your normal household expenses.

The Hospital Indemnity plan provides a daily benefit of $200/person each day of hospitalization because of an illness or injury – up to a total of 180 days beginning with the first day of the hospital stay. Care must be medically necessary, ordered by a physician, and take place in a hospital.

This chart shows the monthly premiums for the Hospital Indemnity Plan. Premiums are made on an after-tax basis. There is a new rate structure and rates for the Hospital Indemnity plan. You can elect coverage for employee, employee plus spouse, employee plus child or children, and employee plus family. For more information, visit the Benefits Website or Contact Risty Benefits at the number listed.

**Short Term Disability**

The last flexible benefit to look at is the Short Term Disability Income Protection Plan. Short Term Disability is provided by Unum through Risty Benefits. This coverage is for the employee only – there is no dependent coverage. Short-Term Disability benefits begin the latter of the expiration of earned sick leave or after 30 days of total disability. The monthly benefit amount is 60% of your monthly salary, up to $866.00 per week. Benefits are paid on a weekly basis. Coverage for new employees generally begins six months after the employee enrolls in the plan. You will not see a deduction for the first six months, but you will also not have Short Term Disability Coverage the first six months. Benefits end the earliest of: the end of the disability – meaning you can return to work, employment in any job/occupation, the employee’s death, or 52 weeks.

This chart shows the monthly premium for Short Term Disability coverage. Contributions for coverage are made on an after tax basis. If you have questions regarding the Short Term Disability coverage, contact Risty Benefits at the number listed or visit the Flexible Benefits website.
Flexible Spending Accounts

The South Dakota State Employee Benefits Program also offers 2 types of spending accounts. The first spending account we will review is the Medical Expense Spending account. A Medical Expense Spending account provides an easy way for you to set aside pretax money to use for medical expenses. You will choose how much you want deducted from your paycheck each month to go into your medical expense spending account. A medical Expense Spending account helps you pay for out-of-pocket medical costs including: deductibles, copayments, dental costs, vision costs, prescriptions and other healthcare costs not covered by health insurance. The majority of eligible out-of-pocket medical expenses will be processed by Dakotacare automatically. Dakotacare will then reimburse you via check or automatic bank deposit. Money set aside in your account can be used to pay for out-of-pocket medical expenses for eligible members of your family, not just those covered by the health plan. If enrolled in the $1800 deductible plan, the medical expense spending account may only be used toward vision, dental and preventive care expenses.

The “Use it or Lose it” rule does apply to the Medical Expense Spending account. Active flexible spending account holders have until September 15 of the following plan year, to spend or incur claims related to their Medical Expense Spending account. The chart on this slide provides the IRS maximum contributions for the calendar year for the medical expense spending accounts. For more information please visit the Benefits webpage.

The second type of Flexible Spending account is the Dependent Care/Day Care Spending account. A Dependent Care account provides an easy way for you to set aside pretax money to use for eligible dependent care and day care only. Eligible dependents include children under age 13 and/or dependent children or a spouse who is physically or mentally unable to care for themselves. Visit Benefits website for further eligibility requirements. Members must submit a claim form to Dakotacare to receive reimbursement. Members will then receive a check or direct deposit reimbursement.

The “Use it or Lose it” rule also applies to the Dependent Care Spending account. Active flexible spending account holders have until September 15 of the following plan year to spend or incur claims related to their Dependent Care/Day Care Spending account. The chart on this slide provides the IRS maximum contributions for the calendar year for the Dependent Care spending accounts.

LEAP

The Latitude Employee Assistance Program, or LEAP, is sponsored by the South Dakota State Employee Benefits Program and provided by APS Healthcare, as a free service offered to benefit eligible employees and dependents. LEAP provides support for personal and work concerns at no cost. With a phone call or click of a mouse, you can get assistance from a professional. Whatever the issue, LEAP can assist you in creating solutions that will allow you to be healthier, happier, and more productive. LEAP is available to you and your dependents 24 hours a day/365 days per year. Benefits include: counseling services, telephonic support, as well as online tools and information. To access the online services, click the LEAP link at the bottom of the slide and enter in the company code southdakota (with no spaces), or call the number listed on the slide.

Life Insurance

Now let’s take a look at the Life Insurance portion of the State Benefits Program. Basic Life Insurance coverage of $25,000 is provided to benefit eligible employees through VOYA Financial at no cost to the employee. The VOYA Financial Life Insurance plan is portable meaning you can continue the policy on your own when you end employment with the state up to the age of 80. Benefit eligible employees are also provided with $25,000 of Accidental Death and Dismemberment coverage through VOYA Financial at no cost to the employee. For more information regarding the Life Insurance visit the South Dakota Flex Benefits website, or call Risty Benefits at the number listed on this slide.
Employees have the option to add additional life insurance coverage through Supplemental Life insurance. You may choose Supplemental Life Coverage at levels of two, three, four or five times your annual earnings through VOYA Financial. At the time of new hire enrollment, you may elect any level of coverage with no questions asked. After the 30-day enrollment period, you may be subject to underwriting if you wish to change the level of life insurance coverage. The maximum amount of supplemental coverage available is $400,000. You pay for coverage through after tax payroll deductions.

Accidental Death and Dismemberment coverage can be added on to the Supplemental Life coverage. AD&D coverage must equal the supplemental life coverage. Rates are per $1,000 of coverage – Please refer to the next slide for the contribution rates. If AD&D coverage is elected, then you may also add this AD&D coverage onto your dependent life insurance.

To calculate your contribution amount: Round your salary up to the next $1,000 level, Multiply your salary by the desired coverage level, Then multiply that amount by the rate for your age group, Finally divide by 1,000. This will give you the amount that you will contribute each pay period for adding supplemental employee coverage.

If you have Employee Supplemental Life coverage, you may purchase $10,000 of Dependent Life Coverage and $10,000 of Dependent AD&D coverage. The coverage and contribution rates apply to all eligible dependents. If you are applying for new dependent coverage outside of your 30 day new hire period, your spouse/child(ren) are subject to underwriting approval. For more information regarding the Life Insurance, visit the Flexible Benefits website or call Risty Benefits at the number listed.

Optional Insurances

The following products are offered through private companies and may be taken with you upon your departure from USD. New York Life – Available at low group rates and, if the participant enrolls within the time limit, does not require a physical examination. This is a “whole life” insurance policy. AFLAC - Offers a variety of products, some are pre-tax and others are post-tax contributions. Please refer to the Aflac flyer and waiver form in your Benefits Packet that you received. On this form you can mark the Aflac products that you are interested in. The Aflac representative will then contact you to set up a one-on-one meeting to go over the policies and the premium rates. If you choose not to elect Aflac insurance at this time, you can fill out the waiver section of the form and return it to Human Resources. There is also an annual enrollment time for Aflac which you will be notified about through your USD email account.

Additional Information

The next few slides go over additional employee information. This includes: leave, reduced tuition, other employee information and important reminders.

Leave

We are first going to discuss some of the leave categories. One of the most common leave categories is annual leave. During the first 6 months of employment you are not able to use your annual leave, however you will be accruing it. Another common leave category is sick leave. There is no waiting period before you can use sick leave. This means sick leave can be used in the pay period after it is accrued. Each calendar year you are allowed 40 hours of accumulated sick leave for personal leave purposes. This personal leave comes out of your sick leave balance, so you must have time accrued in your sick leave in order to take personal leave. Employees may use personal leave for events such as a death in the immediate family and for temporary care of members of the immediate family. Leave can also be classified as FML or Family Medical Leave. The Family Medical Leave Act is a federal law that provides employees with 12 weeks of job protected leave for certain qualifying events. Qualifying events include birth of a child, care for a family member, self-health issues and military deployment. Should an FML event occur
contact Human Resources and a representative will discuss the Family Medical Leave process with you. For additional information about leave please click Leave Policies at the bottom of the slide.

Next we are going to discuss leave accrual. 12 month employees who are 100% time accrue annual leave at 10 hours per month and sick leave at 9.34 hours per month. This equates to 3 weeks of annual leave a year and about 3 weeks of sick leave each year. The maximum accrual for annual leave is 240 hours, however after 15 years of employment the annual leave accrual increases to 13.34 hours per month and the maximum accrual for annual leave increases to 320 hours. There is no maximum accrual for sick leave. Faculty members with 12-month appointments accrue annual and sick leave. Faculty members with 9, 10 or 11 month appointments accrue sick leave only. All regular employees receive their normal pay for 10 legal holidays. These holidays consist of: New Year’s Day, Martin Luther King Jr. Day, President’s Day, Memorial Day, Independence Day, Labor Day, Native American Day, Veterans’ Day, Thanksgiving Day, and Christmas Day. Additional information regarding leave will be discussed during the timesheet and leave reporting orientation. You may also contact Human Resources with questions regarding leave.

**Reduced Tuition**

State employees are eligible to attend State Supported classes offered by an institution under the control of the Board of Regents at one-half tuition, for a maximum of 6 credit hours per semester and a total of 18 per year, on a space available basis, provided the following criteria are met. The employee is eligible for benefits and has been continuously employed by the State of South Dakota for one year or more; The Employee is a resident of South Dakota; the employee is not entitled to other reduced tuition benefits by law; The employee has a grade point average of 2.0 or greater; and the employee is not currently on a prescriptive or work improvement plan. To find out more about your opportunity for reduced tuition and for the application, please visit the link at the bottom of the slide. For additional questions about reduced tuition please contact the Registrar’s office.

**Other Employee Information**

Here are some final employment details. State employees are covered by Worker’s Compensation for injuries arising out of and in the course of employment. An injured employee or their supervisor must complete an electronic first report of injury form within 3 business days of the injury. This form is available at the Benefits website under the Worker’s Comp tab. Social security and Medicare taxes are matched by the state monthly according to Federal regulations. Unemployment benefits are provided according to state regulations. Board of Regents employees are paid monthly on the last working day of the month. Our Pay period runs from the 22nd to the 21st of the month. Employees are required to set up direct deposit for their pay checks. There are also various services and agencies located around campus. There is an information sheet included in your benefits packet and you can find a complete list of Employee Perks and Discounts located on the USD Portal HR Benefits page.

The benefits you choose at the time of new hire enrollment are the benefits you will have for the plan year, unless you have a qualifying Family Status Change event such as: Birth, Marriage, Beginning Employment, Ending Employment, Death, Divorce, or ineligible dependent. For a complete list of the Family Status Change events, visit the Benefits website and click on Forms and Documents and then Family Status Change form. If your event qualifies as a family status change you will have 60 days from the date of the event to make changes to your benefits. These changes can be made by completing the Family Status Change form. Contact the Human Resources department or your HR Partner for guidance on completing this form. You may also make changes to your benefits during the annual enrollment period. This usually takes place during the first two weeks in May. These changes will then be effective July 1st. Please refer to the video called Enrollment Guide for detailed steps on how to complete your online Benefits enrollment. You should also watch the video called Retirement Guide to learn about your retirement options. Remember you MUST complete your ONLINE enrollment for all Benefits within 30 calendar days from your date of hire. If you have any questions during your online enrollment or about any of the benefits, please contact...
the Human Resources Department at 605-677-5671 or contact the applicable agency listed on the Contacts and Resources page found in the Decision Guide on the Benefits webpage.