Flexible Spending Accounts

Employees have the opportunity to enroll in Flexible Spending Accounts which may allow participants to receive a tax savings on day care and medical expenses. Each plan is a maintained as a separate account and funds cannot be comingled. For example, an employee enrolls in Medical Reimbursement and Dependent Care. The participant files a claim for medical expenses in excess of available funds in the medical reimbursement account. The amount in excess of available funds cannot be claimed against the dependent care account.

Participants have 60 days into the new the plan year in which to request reimbursements for eligible expenses incurred in 2016. All claims must be received to Southern Administrators & Benefit Consultants (SABC) by **March 1st** to receive reimbursement. Claims may be submitted via fax, email, online, mail, or walk-in (Jackson area residents).

The plan includes a rollover provision in which a maximum of $500 unclaimed funds in the 2016 Medical Reimbursement account will rollover to the 2017 Medical Reimbursement account. This rollover will occur after the March 1st reimbursement deadline has expired. The rollover provision does not apply to Dependent Care.

The plan year is January 1 to December 31.

Types of Plans

Medical Expense Reimbursement Plan – enables participants to receive reimbursement for eligible medical expenses. "Pre-tax" salary reductions are credited to a reimbursement account and are refunded to you as expenses are incurred. Expenses may include costs for deductibles, co-insurance expenses not reimbursed through insurance or any other source, eyeglasses, contact lenses, hearing aids, or any family medical expenses that would qualify as a deduction on your federal income tax return. The annual limit per participant is $2,550.

Dependent Care Reimbursement Plan – provides for the reimbursement of eligible employment-related dependent day care expenses. Expenses may include the costs for in-house or on-site care centers (caring for six or more individuals) or for at-home services provided by third parties who meet applicable state and federal law standards. The person being cared for must be either: a child or other dependent under age 13 that you are entitled to claim as a dependent on your income tax return, or your spouse or other legal dependent who is physically or mentally incapable of caring for himself or herself. The annual limit per family is $5,000.

Ineligible Expenses – There are certain expenses that are not eligible for reimbursement under your flexible benefit plan. Some of the more common ones include:

- Expenses claimed as deductions for income tax purposes
- Medical expenses which have been reimbursed through a medical insurance policy or any other source
- Any expense for cosmetic purposes
- Over-the-counter drug purchases, unless prescribed by a physician

Benefits include:

- Pharmacy debit cards
- Claims processing via mail, fax, online, email, or walk-in (for employees who live in the Jackson area)
- Participants will be contacted via phone or email on the day a claim is received if SABC is unable to process the request for any reason
- Choice of receiving correspondence from SABC via mail or email
- One-day turnaround on claims
- Direct deposit of reimbursed monies
- Participants will receive information about their account balance and claims payment information with each reimbursement
- Access to individual account information via secure website

Pharmacy Debit Card - If you participate in Medical Reimbursement and apply for the pharmacy debit card, you may swipe the debit card at a **participating pharmacy** to pay for prescriptions. This process will automatically debit your Medical Reimbursement account for the cost of the prescription and eliminates the need for sending in receipts for prescription reimbursement. A list of participating pharmacies is available at http://www.sabcflex.com/content/sabc-flexrx-online-drugstore. The participant is responsible for replacing cards that have been lost, stolen, destroyed, etc. and will pay a $10.00 reissue fee to the card company. Please note: the debit card has a 5-year expiration date from the date of issue.

Employees electing to enroll in coverage as a new participant, change an annual election, or cancel existing coverage are required to complete The University of Mississippi: Benefits Enrollment/ Change Form. Instructions are provided to guide you through the form completion process.

All coverage changes become effective January 1, 2017.Completed forms must be received in the University's Human Resources Office (108 Howry Hall) no later than Wednesday, December 14, 2016.

IMPORTANT: PLEASE READ AS ACTION MAY BE REQUIRED.

- In order to be in compliance with From 1095-C and Affordable Care Act requirements, please verify that all names, social security numbers and dates of birth are correct for any family members who are currently enrolled or will be enrolled on an insurance plan. This can be done by accessing the Beneficiary/Dependents section of the online Open Enrollment portal in myOleMiss.

- When enrolling eligible dependents on an insurance plan, a copy of the dependent's Social Security Card **MUST** be provided to the Human Resources office. Furthermore, all listed names on insurance applications must be listed as a legal name, nicknames are not permitted.

- In order to ensure the accuracy of W-2 processing for 2016, please verify all contact information (address, phone number etc.) within myOleMiss. This can be accessed under the 'Employee' tab and then by clicking the MyHRtools drop down box and then selecting Address & Communication Preferences. If any information is incorrect, please update accordingly. Please note that updating your contact information within myOleMiss will only update your address with the University, and does not update your contact information with insurance and retirement vendors. Please also complete a **Benefits Information Change form** to update your information with each respective vendor. When changing your contact information within myOleMiss, a link to this form will populate on the right side of the screen. Below is the link to the form. http://www.olemiss.edu/hr/_files/benefits/InfoChangeForm.pdf

Enrollment Application Instructions:

Enroll as a New Participant

Employees interested in participating in a Flexible Spending Account Plan must complete **The University of Mississippi: Benefits Enrollment/Change Form**.

- Page 1 - Provide personal information in the shaded section at the top of the form.
- Page 2 – Complete the section designated for **Flexible Spending Accounts (FSA).**
- Select the plan(s) in which you wish to enroll and provide the amount you would like deducted each pay period. Twelve-month (12) employees will incur 24 deductions and nine-month (9) faculty will incur 18 deductions.
    - ***Pharmacy FlexCard*** (This section only applies to employees participating in the Medical Reimbursement Plan. Do not complete for a Dependent Care Plan).
- Page 4 - Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form

SABC FlexCard Enrollment Form – This form must be completed by all Medical Reimbursement Account participants enrolling in the pharmacy flex card.

Direct Deposit Authorization Form – All Flexible Spending Account participants must complete this form and provide a voided check. Reimbursements will be direct deposited into the bank account provided on this form.

Change Plan Option

Employees who wish to change their annual election for 2017 must complete **The University of Mississippi: Benefits Enrollment/Change Form**.

- Page 1 - Provide personal information in the shaded section at the top of the form.
- Page 2 – Complete the section designated for **Flexible Spending Accounts (FSA).**
- Select the plan(s) in which your election will change. Provide the amount you would like deducted each pay period. Twelve-month (12) employees will incur 24 deductions and nine-month (9) faculty will incur 18 deductions.
    - ***Pharmacy FlexCard*** (This section only applies to employees participating in the Medical Reimbursement Plan. Do not complete for a Dependent Care Plan).

- Page 4 - Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form

Cancellation of Existing Coverage

Employees cancelling Medical Reimbursement and/or Dependent Care Accounts must complete **The University of Mississippi: Benefits Enrollment/Change Form**.

- Page 1 - Provide personal information in the shaded section at the top of the form.
- Page 2 – Complete the section designated for **Flexible Spending Accounts (FSA).**
- Select the plan(s) in which you will stop participation. Write zero "0" in the Pay Period Election field.
- Page 4 - Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form

The University of Mississippi: Benefits Enrollment/Change Form

Employee Name:	Date of Hire:
Address:	University ID Number:
City/State/Zip:	Home Phone:
SSN: Date of Birth:	Work Phone:
Email Address:	Gender: ☐ Male ☐ Female
Status: ☐ 9-Month ☐ 12-Month Pay Mode: Semi-Monthly	Marital Status:

Check One: ☐ New Hire ☐ Legal Marriage/Divorce ☐ Birth/Adoption ☐ Open Enrollment
☐ Other Status Change ____________________________ ☐ Date of Qualifying Event _________________

University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods while premiums for 9-month faculty are deducted over 18 pay periods.

Spouse/Dependent Information – List all dependents you wish to cover or drop from the insurance plans you have selected. Check all benefits that apply.

Last Name, First Name, MI	Social Security #	M/F	Birth Date	Relationship	Disabled Dependent (yes/no)	Drop/Add	Dental	Vision	FSA	AD&D	LTD	UNUM Life	Cancer Plan

Dental - Delta Dental (Group #1126) Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Low Plan (division: 00002)	☐ $26.84 / $35.79	☐ $56.00 / $74.67
High Plan (division: 00001)	☐ $38.72 / $51.63	☐ $80.56 / $107.41

FOR HUMAN RESOURCES ONLY
Effective Date: ________________

Are you or your family member(s) currently covered under another dental plan: ☐ **Yes** ☐ **No**

If yes, provide the name of the participant(s) with other coverage. ____

☐ **Waive/Cancel Coverage**

Vision – Davis Vision (Group: UMM) Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Employee Only 12-month / 9-month	Employee + 1 12-month / 9-month	Family 12-month / 9-month
☐ $7.80 / $10.40	☐ $14.08 / $18.77	☐ $21.89 / $29.19

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY
Effective Date: ________________

The University of Mississippi: Benefits Enrollment/Change Form

Flexible Spending Accounts (FSA)

Contributions are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Pay Period Election

Dependent Care Spending Account ☐ $_________ (annual maximum $5,000)

Unreimbursed Medical Spending Account ☐ $_________ (annual maximum $2,550)

Prescription FlexCard ☐ Yes ☐ No

FOR HUMAN RESOURCES ONLY

$__________ annual election (D/C)
$__________ annual election (M/R)

Effective Date: _________________

☐ Waive Participation (To cancel participation in an existing plan, write '0' in the blank next to the respective plan type.)

Accidental Death and Dismemberment – National Union Fire Insurance Company of Pittsburgh #PAI9032465

Section 125 Cafeteria Plan

Amount of coverage available is a minimum of $10,000 and a maximum of $250,000 (in $10,000 increments), with amounts above $150,000 not to exceed 10x base annual earnings. If you insure your spouse and/or dependent children under this plan, the amount of insurance applicable to the members of your family is based on the composition of your family at the time of loss and is expressed as a percentage of the employee's coverage.

☐ Employee Only ☐ Family Coverage Amount: $______________

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

12-Month Cost / 9-Month Cost $_________

Effective Date: _________________

Beneficiary Designation: Designate beneficiary(ies) for your Accidental Death & Dismemberment policy. The employee is beneficiary for dependent coverage unless otherwise indicated.

Primary %	Secondary %	Last Name, First Name, MI	Relationship	M/F	Social Security #	Birth Date	Dependent Beneficiary (if not employee) mark as 'X'	Trustee for Minor

Long-Term Disability (LTD) – Standard Insurance Company

You may elect disability coverage of 60% of your base salary up to $5,000 per month, until age 65, after a 90 or 180 day elimination period. *Pre-Existing Limitation may apply. **Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability will be required and The Standard Insurance Company has the right at that time to refuse the request for coverage.

Premiums are withheld 12-Month / 9-Month

☐ Plan 1 (90-day option) ☐ Plan 2 (180-day option)

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

Base Annual Earnings $______________

Position Title: ____

Hours Worked Per Week: _______________

Effective Date: _________________

The University of Mississippi: Benefits Enrollment/Change Form

Supplemental Term Life with AD&D – UNUM

Premiums are withheld 12-Month / 9-Month

** Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability must be provided and UNUM has the right at that time to refuse the request for coverage.

Employee Coverage ** Amounts above $150,000 or 3 times salary, whichever is less, require Evidence of Insurability.

☐ 1X Salary ☐ 2X Salary ☐ 3X Salary

☐ 4X Salary ☐ 5X Salary ☐ 6X Salary

Maximum coverage available is 6X your annual base salary rounded to the Next higher multiple of $1,000 to a maximum of $600,000

☐ Waive Employee Coverage

FOR HUMAN RESOURCES ONLY

Annual Salary $ ____________________

Coverage Amount $___________________ 12-Month / 9-Month Cost $___________

Effective Date: _______________

Spouse Coverage ** Amounts above $25,000 require Evidence of Insurability. Spouse coverage cannot exceed 50% of employee's coverage amount rounded down to the nearest $25,000.

☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

☐ Waive Spouse Coverage

FOR HUMAN RESOURCES ONLY

Coverage Amount $___________________ 12-Month / 9-Month Cost $___________

Effective Date: _______________

Dependent Child(ren) Coverage ** All children are covered from birth to 6 months for $5,000 and at $10,000 from 6 months to age 19, or 25 if full-time student.

☐ Dependent Child(ren) Coverage $10,000

☐ Waive Dependent Child(ren) Coverage

FOR HUMAN RESOURCES ONLY

12-Month / 9-Month Cost $___________

Effective Date: _______________

Primary %	Secondary %	Last Name, First Name, MI	Relationship	M/F	Social Security #	Birth Date	Trustee for Minor

Delayed Effective Date ***Employee:*** Insurance will be delayed for Employees not actively at work until the first of the month following the date they return to work. Regularly scheduled vacation time is considered active employment. ***Dependent:*** Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disabled.

Policy Limitations and Exclusions **I understand all the policy exclusions and Limitations listed in the certificate of coverage.** If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

The University of Mississippi: Benefits Enrollment/Change Form

Cancer/Dreaded Disease & Intensive Care - American Heritage (Underwritten by AllState)

This plan is subject to underwriting. Those electing coverage will be contacted to complete a medical health statement. Failure to complete the medical health statement in a timely manner will result in non-issuance of the policy.

Select only one plan type. Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Low Option - no Intensive Care (CP10A)	☐ $ 9.40 / $12.52	☐ $15.50 / $20.64
High Option - no Intensive Care (CP10B)	☐ $14.98 / $19.96	☐ $25.82 / $34.40
Low Option - $300/day Intensive Care (CP10A / ICR2)	☐ $12.40 / $16.52	☐ $21.49 / $28.64
High Option - $300/day Intensive Care (CP10B / ICR2)	☐ $17.98 / $23.96	☐ $31.81 / $42.40
Low Option - $600/day Intensive Care (CP10A / ICR2)	☐ $15.39 / $20.52	☐ $27.49 / $36.64
High Option - $600/day Intensive Care (CP10B / ICR2)	☐ $20.97 / $27.96	☐ $37.81 / $50.40

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: ________________

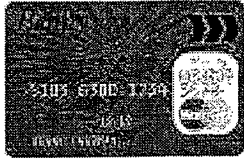
Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization

I will automatically be enrolled in the Cafeteria Plan and I understand the following:

- * My salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit option(s) I have elected under the Cafeteria Plan.
- My Social Security benefits may be reduced due to my participation in the Cafeteria Plan.
- **Elections made will be irrevocable for the plan year except for modifications due to a qualified Change in Status (divorce, marriage, death of spouse/dependent, birth/adoption of a child, change of employment status of me or my spouse, cost or coverage\change, HIPAA Special Enrollment Rights, or other event specified by the IRS – consult your employer for details regarding your plan) provided I request election change within 60 days after the qualified Change in Status.**
- If my salary reduction for the elected insurance benefit(s) are increased or decreased while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.
- Prior to each plan year, I will be given the opportunity to change my benefit election. If I fail to complete and return a new election form within the regular enrollment period, preceding each play year, I understand my election will remain the same.
- My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.
- I understand my elected benefits will cease upon my termination of employment.
- If I participate for dependent care or premium reimbursement expenses, I will be reimbursed up to the amount incurred during the play year, not to exceed the amount of my dependent care balance.
- If I participate in the unreimbursed medical expenses, I will be reimbursed for out-of-pocket medical expenses up to the amount Incurred (date service was provided, not paid) during the benefit year, not to exceed my plan year election.
- If I participate in a flexible spending account(s), any funds remaining after the end of the sixty (60) days grace period, following the end of the benefit year, will be forfeited to my employer.
- I have been explained the flexible spending reimbursement procedures and the requirements of the plan, I understand my reimbursements will be based on certain required third party documentation and eligibility of the expense. I understand that upon submission of each claim, I certify that the documentation submitted is valid and eligible under the guidelines of the plan. Submission of falsified and/or inaccurate information may result in disciplinary action and/or penalties.
- I understand by participating under unreimbursed medical expenses I can only claim for expenses incurred prior to my termination of employment. If I have a positive balance, I can extend my unreimbursed medical expenses because of a COBRA qualifying event and I will be given an opportunity to continue on a self-pay basis.
- I understand that privacy statements are available via the University website at http://www.olemiss.edu/hr/benefits.html. If I do not have access to the internet I can request a paper copy from the Human Resources Department. As an 'employee', I acknowledge that I am the subscriber of coverage, and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made, and every three years, to my email address on file with the University.

**THIS ELECTION AND SALARY REDUCTION AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S CAFETERIA PLAN DOCUMENT.

EMPLOYEE SIGNATURE ______________________________ **DATE SIGNED** ________________



SABC FLEXCARD ENROLLMENT FORM

SECTION 1

1. COMPANY NAME	2. DATE OF BIRTH
3. EMPLOYEE NAME (First, Last)	4. SOCIAL SECURITY #
5. EMPLOYEE MAILING ADDRESS (STREET OR BOX, CITY, STATE, ZIP)	6. DAYTIME PHONE
7. EMAIL ADDRESS	8. EVENING PHONE

You will receive (2) cards, at no charge. If you would like to order additional cards, please complete the dependent information below. Each additional card is $10.00, and will be deducted from your eligible balance.

SECTION 2 (ONLY IF ORDERING ADDITIONAL CARDS AT $10.00 EACH)

DEPENDENT NAME	SOCIAL SECURITY NUMBER
DEPENDENT NAME	SOCIAL SECURITY NUMBER

I am requesting a debit card to be used for prescription and over-the-counter drugs in conjunction with my Unreimbursed Medical spending account. I understand that I can only use this card at participating merchants and retailers. I also understand that a fee of $__________per ____________ will be deducted, tax free from my paycheck, to cover the cost of the card. My card is valid for (5) years and will remain in effect during that period, unless I cancel the card, terminate employment or cease to be a participant in Unreimbursed Medical.

I have been explained and I understand the terms and conditions of the card. If I should terminate my employment, I understand that my card will no longer be valid and I must submit future claims to SABC for reimbursement.

EMPLOYEE SIGNATURE	**DATE**

SABC FLEXIBLE SPENDING CAFETERIA PLAN, DIRECT DEPOSIT AUTHORIZATION

Check the Appropriate Box

New Setup ☐ Change Information ☐ Cancel Direct Deposit ☐

I ______________________ an Employee of ______________________, authorize SABC to:
(*Insert Employee Name*) (*Insert Name of Employer*)

Initiate electronic credit entries from my Flexible Spending Cafeteria Plan account, based on each claim for reimbursement I submit to SABC, and if necessary, any debit entries and adjustments for any credit entries in error. I acknowledge and understand that ***it is my responsibility*** to check the account on the next business day, after receiving email notification of payment, to ensure that the account was properly credited. I understand that I am required to have an email account in order to be notified a payment was issued. I understand SABC will not be liable for any bank charges resulting from problems associated with payment by direct deposit such as: my error in providing the correct bank information, or my failure to notify SABC when a bank account is closed. If SABC is charged a fee, by any financial institution in regard to incorrect or closed account information due to failure on my part, SABC reserves the right to transfer those fees to me.

I acknowledge that the origination of an Automated Clearing House (ACH) transaction to my Checking Account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it by filing a new form with SABC.

(Please Complete All Fields)

______________________ / ______________________
Employee Name ***(Please Print)*** ***Daytime phone***

____
Employee Signature

____
Employee Social Security Number

____
Signature of an Authorized Signor on the Bank Account

____
Employee Email Address for Notification **(Required)**

____
Print Name of Above Signatory

____
Date

____
If Signor of Account is other than Employee, indicate relationship to Employee.

REQUIRED

TAPE VOIDED CHECK HERE. DO NOT STAPLE.

BANK INFORMATION

____
Financial Institution Name (*Please Print*)

____
Financial Institution City and State

__ __ __ __ __ __ __ __ __
Financial Institution Routing/Transit (ABA) Number (9 digits)

____
Your Account Number

Please double check the FDIC Bank Routing/Transit and your bank account number for accurate entry, then attach a Voided Check and forward this original document to your Human Resource Department.

Provided by:

(SABC) P.O. Box 2449 * Madison, MS 39130-2449 * (601) 856-9933 * www.sabcflex.com