# State and School Employees' Health Insurance Plan

University faculty and staff have an opportunity to enroll in health insurance with the State and School Employees' Health Insurance Plan. Two plan options are available. Both plans provide the same benefits (i.e. wellness/preventive, maternity, basic care, etc.); however, deductibles and premiums are different. Below is a summary of each plan. Additional information is available on the Human Resources website at http://www.olemiss.edu/hr/benefits.html or by visiting the State Health Plan website at http://knowyourbenefits.dfa.state.ms.us/.

## Coverage Options

### BASE COVERAGE (High Deductible Health Plan)

Base Coverage meets the federal government's criteria of a qualifying high deductible health plan under Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 in regard to establishing a Health Savings Account. Base Coverage includes a combined medical and pharmacy high deductible. Allowable charges for prescription drugs are applied to the calendar year deductible. After the calendar year deductible has been met, participants will pay applicable prescription drug co-payments. The chart below outlines deductibles, coinsurance amounts, and coinsurance/co-payment maximums.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Calendar Year Deductible - Individual Coverage | $1,800 | |
| Calendar Year Deductible - Family Coverage | $3,000 | |
| Co-Insurance * | 80/20 | 60/40 |
| Coinsurance/Co-payment Maximum | $2,500 / $5,000 | $4,000 /$8,000 |
| Out-of-Pocket Limit (individual / family) | $4,300 / $8,000 | N/A |

*SOME BENEFITS MAY BE PAID AT A DIFFERENT CO-INSURANCE (SEE SPD).

### SELECT COVERAGE

Select Coverage has separate medical and prescription drug deductibles. The chart below outlines deductibles, coinsurance amounts, and coinsurance maximums.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Individual Calendar Year Medical Deductible | $1,000 | $2,000 |
| Family Calendar Year Medical Deductible | $2,000 | $4,000 |
| Co-Insurance * | 80/20 | 60/40 |
| Individual Medical Coinsurance Maximum | $2,500 | $3,500 |
| Out-or-Pocket Limit (individual / family) | $6,350 / $12,700 | N/A |
| Individual Prescription Drug Deductible | $75 | |

*SOME BENEFITS MAY BE PAID AT A DIFFERENT CO-INSURANCE (SEE SPD).

# Premiums

**Legacy Employees**

| | Select Coverage Option | | Base Coverage Option | |
|---|---|---|---|---|
| **Coverage** | **Legacy Monthly Premiums** | | **Legacy Monthly Premiums** | |
| | **12-month** | **9-month** | **12-Month** | **9-Month** |
| ***Employee** | $ 20.00 | $ 26.68 | $0 | $0 |
| **Employee & Spouse** | $463.00 | $617.32 | $389.00 | $518.68 |
| **Employee & 1 Child** | $175.00 | $233.32 | $101.00 | $134.68 |
| **Employee & Children (2 or more)** | $332.00 | $442.68 | $258.00 | $344.00 |
| **Employee, Spouse, & Children** | $667.00 | $889.32 | $593.00 | $790.68 |
| ***The University pays $356.00 for employee only coverage** | | | | |

**Horizon Employees**

| | Select Coverage Option | | Base Coverage Option | |
|---|---|---|---|---|
| **Coverage** | **Horizon Monthly Premiums** | | **Horizon Monthly Premiums** | |
| | **12-month** | **9-month** | **12-Month** | **9-Month** |
| ***Employee** | $ 38.00 | $ 50.68 | $0 | $0 |
| **Employee & Spouse** | $481.00 | $641.32 | $389.00 | $518.68 |
| **Employee & 1 Child** | $193.00 | $257.32 | $101.00 | $134.68 |
| **Employee & Children (2 or more)** | $350.00 | $466.68 | $258.00 | $344.00 |
| **Employee, Spouse, & Children** | $685.00 | $913.32 | $593.00 | $790.68 |
| ***The University pays $356.00 for employee only coverage.** | | | | |

**Legacy Employees –** All current UM employees hired prior to January 1, 2006 **OR** new employees hired on or after January 1, 2006 who have been employed full-time by any State of Mississippi agency covered by the Plan (such as a community/junior college, public library, public school district, other State agency or university).

**Horizon Employees –** Any employees initially hired by any State of Mississippi agency on or after January 1, 2006.

Employees electing to enroll in coverage as a new participant, change plan option, add or drop dependents, or cancel existing coverage are required to complete the State of Mississippi State and School Employees' Health Insurance Plan Application for Coverage. Instructions are provided to guide you through the form completion process.

**All coverage changes go into effect January 1, 2017. Completed forms must be received in the University's Human Resources Office no later than November 4, 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 enrolling in the State Health Plan must complete the Application for Coverage.

- ***Section A: Enrollee Information*** – all fields must be completed
- ***Section B***: ***Health Insurance Membership Agreement Authorization*** – mark the box to ADD, CONTINUE, AND/OR CHANGE COVERAGE then sign and date.
- ***Section C: Coverage*** –
  - Mark the box for Enrollee Type (Definition for legacy and horizon are provided above)
  - Mark the box for Coverage Type
  - Mark the box for Coverage Option (Plan options are defined in the above tables)
  - Answer question(s) related to tobacco usage
- ***Section D: Other Coverage Information*** – Answer Medicare question and provide policy information (if applicable).
- ***Page 2*** – provide name and social security number
- ***Section E: Dependents*** –
  - List family members who will be covered under the plan (social security number, copy of social security card and date of birth are required)
  - Answer Medicare question and supply policy information.
- ***Section F: Change Information***
  - Mark the boxes Add Enrollee and Open Enrollment and provide the Requested Effective Add Date as 1/1/2017

## Add a Dependent to Existing Coverage

Employees adding a spouse or child(ren) to their existing State Health Plan coverage must complete the Application for Coverage.

- ***Section A: Enrollee Information*** – all fields must be completed
- ***Section B***: ***Health Insurance Membership Agreement Authorization*** – mark the box to ADD, CONTINUE, AND/OR CHANGE COVERAGE then sign and date.
- ***Section C: Coverage*** –
  - Mark the box for Enrollee Type (Definition for legacy and horizon are provided above)
  - Mark the box for Coverage Type
  - Mark the box for Coverage Option (Plan options are defined in the above tables)

- Answer question(s) related to tobacco usage
- ***Section D: Other Coverage Information*** – Answer Medicare question and provide policy information (if applicable).
- ***Page 2*** – provide name and social security number
- ***Section E: Dependents*** –
  - List family members who will be added to the plan (social security number, copy of social security card and date of birth are required)
  - Answer Medicare question and supply policy information.
- ***Section F: Change Information***
  - Mark the boxes Add Dependent and Open Enrollment and provide the Requested Effective Add Date as 1/1/2017

## Drop a Dependent from Existing Coverage

Employees wishing to remove a spouse or child(ren) from their existing State Health Plan coverage must complete the Application for Coverage.

- ***Section A: Enrollee Information*** – all fields must be completed
- ***Section B***: ***Health Insurance Membership Agreement Authorization*** – mark the box to ADD, CONTINUE, AND/OR CHANGE COVERAGE then sign and date.
- ***Page 2*** – provide name and social security number
- ***Section F: Change Information***
  - Mark the box Drop Dependent(s)
  - Mark the 'other' box and write Open Enrollment
  - Provide the name, social security number, and requested termination date (12/31/2016)

## Change Plan Option

Employees who wish to change their coverage from Base to Select or Select to Base must complete the Application for Coverage.

- ***Section A: Enrollee Information*** – all fields must be completed
- ***Section B***: ***Health Insurance Membership Agreement Authorization*** – mark the box to ADD, CONTINUE, AND/OR CHANGE COVERAGE then sign and date.
- ***Page 2*** – provide name and social security number
- ***Section E***: ***Change Information***
  - Mark the box for Change Coverage Option and choose either Base Coverage (High Deductible) or Select Coverage

## Cancellation of Existing Coverage

Employees cancelling coverage under the State Health Plan must complete the following sections of the Application for Coverage.

- ***Section A: Employee/Employer Information*** – all fields must be completed
- ***Section B***: ***Health Insurance Membership Agreement Authorization*** – mark the box to WAIVE COVERAGE then sign and date.
- ***Page 2*** – provide name and social security number

# STATE OF MISSISSIPPI
# STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
# APPLICATION FOR COVERAGE

**PLEASE PRINT**

## Section A: Enrollee Information (all fields are required)

**Employer Name**
University of Mississippi

| **Social Security Number** | **First Name** | **MI** | **Last Name** | |
|---|---|---|---|---|
| **Home Address** | | **City** | **State** | **ZIP** |
| **Primary Telephone Number** | **Secondary Telephone Number** | **Personal Email Address** | | |
| **Marital Status** ☐Single ☐Married | **Gender** ☐Male ☐Female | **Date of Birth (mm/dd/yyyy)** | **Date of Employment/Retirement** | |

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: _____

_____

If married, is your spouse a Plan participant? ☐Yes ☐No If yes, Spouse Name and SSN: _____

## Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

☐ **I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE** for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

☐ **I hereby WAIVE COVERAGE in the State and School Employees' Health Insurance Plan.** I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. **If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.**

Enrollee Signature: _____ Date: _____

## Section C: Coverage

| **Enrollee Type**: | **Coverage Type**: | **Coverage Option:** (Choose Only One) | **Do you have Medicare?** ☐Yes ☐No |
|---|---|---|---|
| ☐ Employee - Legacy | ☐ Enrollee Only | ☐ Select | **Medicare Number:** _____ |
| ☐ Employee - Horizon | ☐ Enrollee + Spouse | OR | ☐ "A" Effective Date: _____ |
| ☐ Retiree | ☐ Enrollee + Child | ☐ Base (HIGH DEDUCTIBLE) | ☐ "B" Effective Date: _____ |
| ☐ COBRA | ☐ Enrollee + Children | | **Reason for Entitlement:** |
| ☐ Surviving Spouse | ☐ Enrollee + Spouse & Child(ren) | | ☐ Age ☐ ESRD ☐ Disability |

Are you a tobacco user? ☐Yes ☐No If yes, are you interested in participating in the Plan's free cessation program? ☐Yes ☐No

## Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐Yes ☐No If yes, please provide the following:

| | **1.** | **2.** | **3.** | **4.** |
|---|---|---|---|---|
| **Name of Individual Covered:** | | | | |
| **Policyholder's Name:** | | | | |
| **Policyholder's Date of Birth:** | | | | |
| **Policyholder's Insurance Effective Date:** | | | | |
| **Policy Number:** | | | | |
| **Policyholder's Employment Status (**Circle**):** | Active, Retiree or COBRA | Active, Retiree or COBRA | Active, Retiree or COBRA | Active, Retiree or COBRA |
| **Insurance Company Name address & phone #:** | | | | |
| **Coverage Type (**Circle**):** | Group or Non-Group | Group or Non-Group | Group or Non-Group | Group or Non-Group |

| Enrollee Last Name: | First Name: | Enrollee SSN: |
|---|---|---|
| | | |

## Section E: Dependents

| Dependents to be Covered (Last Name, First Name, MI) | Relation to Enrollee | Social Security Number | Date of Birth (mm/dd/yyyy) | Address (if different from Enrollee) | Current Status |
|---|---|---|---|---|---|
| 1. | Spouse<br>☐ Male<br>☐ Female | | | | Employed?<br>☐ Yes<br>☐ No |
| 2. | ☐ Son<br>☐ Daughter | | | | ☐ Child under 26<br>☐ Disabled |
| 3. | ☐ Son<br>☐ Daughter | | | | ☐ Child under 26<br>☐ Disabled |
| 4. | ☐ Son<br>☐ Daughter | | | | ☐ Child under 26<br>☐ Disabled |

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No
If yes, please provide the following:

| Name | Medicare Number | Part A Effective Date | Part B Effective Date | Medicare Reason |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## Section F: Change Information

☐ **Add Enrollee**: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce
☐ Other: _____ Requested Effective Date: _____

☐ **Add Dependent(s)**: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: _____
(List all dependents in Section E.) Qualifying Event/ Effective Date: _____

☐ **Change Coverage:** ☐ Base Coverage ☐ Select Coverage

☐ **Drop Dependent(s)**: ☐ Divorce ☐ Deceased ☐ Other: _____
Provide information below for dependents to be dropped:

| Name | Social Security Number | Requested Termination Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

☐ **Other Changes** (Explain):

**FOR EMPLOYER / ADMINISTRATOR USE ONLY:** **GROUP NUMBER:**_____
❑ New Legacy Employee, Requested Effective Date: _____
❑ New Horizon Employee, Requested Effective Date: _____
❑ Retiree, Requested Effective Date: _____
❑ COBRA, Requested Effective Date: _____
❑ Surviving Spouse, Requested Effective Date: _____
❑ Change(s), Requested Effective Date: _____

**ENTERED BY:** _____
**DATE:** _____

**VERIFIED BY:** _____
**DATE:** _____