University of Missouri – 2017 Benefits Change Form (Part 1 of 2)

TOBACCO ATTESTATION 2017

The University of Missouri System promotes and supports healthy lifestyles for our faculty and staff through both our benefits and wellness programs. We are continuing our efforts by allowing employees to earn a tobacco-free premium discount on 2017 medical insurance premiums totaling $50.00 monthly.

For purposes of this discount:

- "Tobacco-free" means that the employee and all dependents covered by a university medical plan have been and will continue to be tobacco free starting at least three months prior to January 1, 2017, or your *medical coverage effective date, and will not use tobacco products through December 31, 2017.
- "Tobacco" includes any form of tobacco products that are smoked (e.g., cigarettes, cigars, pipes); applied to the gums, chewed, or ingested (e.g., dipping or chewing leaf tobacco); and/or inhaled (e.g., snuff or electronic cigarettes).

Complete and submit the following attestation to indicate whether you are or are not claiming eligibility for the tobacco-free premium discount.

Please check the appropriate box:

- ☐ I certify that I and my medical insurance dependents are tobacco free according to the definition above, therefore making me eligible for the tobacco-free premium discount.
- ☐ I certify that I and/or some or all of my medical insurance dependents are not tobacco free according to the definition above, therefore making me ineligible for the tobacco-free premium discount.
- ☐ I and/or my covered dependent(s) currently use tobacco. I/we agree to participate in a tobacco cessation program. I understand that to qualify for the tobacco-free premium discount from January 1, 2017, to June 30, 2017, enrollment in a tobacco cessation program is required. I understand that to continue the tobacco-free premium discount for the second half of 2017 (from July 1, 2017, to December 31, 2017) I must complete another attestation by June 30, 2017, and confirm either that I and my covered dependents are tobacco free or in a cessation program.
- ☐ I plan to waive medical coverage through the University of Missouri, therefore making me ineligible for the tobacco-free premium discount.
- ☐ I decline to respond to this Tobacco Attestation, therefore making me ineligible for the tobacco-free premium discount.

I understand that I am no longer eligible for the premium discount if I (the employee) and/or any of my enrolled dependents begin or resume use of tobacco products after claiming the discount, and I must report this change to the HR Service Center (573-882-2146 or HRServiceCenter@umsystem.edu) or my Total Rewards Generalist (TRG) (http://umurl.us/CBR). I understand that if I (the employee) and/or my enrolled dependents use tobacco products and do not notify the university via the HR Service Center or my Total Rewards Generalist, or if I falsify my tobacco-free status in this attestation, I may face penalties including retroactive collection of additional premiums or cancellation of my health coverage.

☐ **I hereby certify that all information provided by me on this form is complete and accurate and that I understand the previous paragraph.**

The university is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all health plan participants. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Healthy for Life wellness team at 573-884-1312 or at wellness@umsystem.edu and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

***For members with medical insurance coverage effective after January 1, 2017, or after:**

If I enroll in medical insurance coverage after the Annual Enrollment period with an effective date on or after January 1, 2017, I understand that I may participate in the tobacco-free premium discount through December 31, 2017. I must complete a Tobacco Attestation within thirty-one (31) days of my medical coverage effective date, indicating I and my covered dependents are tobacco free, or I or my covered dependents are a tobacco user that will actively participate in a tobacco cessation program. I understand the Tobacco Attestation must be submitted to the HR Service Center, by fax or mail, within thirty-one (31) days of my medical coverage effective date. If I or my covered dependent(s) attest to participate in a tobacco cessation program, I understand that I and my covered dependent(s) must enroll in the program within thirty-one (31) days of my medical coverage effective date. Once enrolled in a program, I or my covered dependent(s) must begin actively participating by no later than sixty (60) days of my medical coverage effective date.

This Attestation does not automatically guarantee eligibility for the tobacco-free premium discount in future years.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a related federal law that expanded the HIPAA privacy, security, and enforcement requirements. The

University of Missouri Medical Benefits Plan (the Plan) will not use or disclose your protected health information, including information you provide in this Tobacco Attestation, without your authorization, except for purposes of treatment, payment, health care operations, Plan administration, or as required or permitted by law. A description of the Plan's permitted uses and disclosures of your protected health information, and your rights and protections under the HIPAA privacy rules, is set forth in the Plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Total Rewards website at http://umurl.us/notices.
The Plan also will comply with applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Plan or its business associates discover a breach involving unsecured protected health information.

Signature	Printed Signature
Date	Employee ID Number

CAMPUS CONTACT INFORMATION

Columbia, System, and Hospital Campus
HR Service Center (573) 882-2146
Fax: (573) 882-9603
hrservicecenter@umsystem.edu

Rolla Campus
Phone (573) 341-4241
Fax: (573) 341-4984
benefits@mst.edu

Kansas City Campus
Phone (816) 235-1621
Fax: (816) 235-5515
benefits@umkc.edu

St. Louis Campus
Phone (314) 516-5639
Fax: (314) 516-6463
umslbenefits@umsl.edu

University of Missouri – 2017 Benefits Change Form (Part 2 of 2)

Employee Last Name	Employee First Name	MI	Employee ID (not SSN)	
Street			Hire Date	Date of Birth
City	State / Zip / Home Phone		Work Phone	Gender

BENEFIT ELECTION INSTRUCTIONS

- Changes to your medical, dental, or vision enrollment elections, at a time other than the Annual Enrollment change period, require that you have a change in family status. If you have one of the changes listed under Family Status Change (section I), complete sections I, II, III, and IV.
- Make your benefit selections (section I)
  - Your contribution rates are dependent upon the attestation you completed in Part 1. If you certified you and your medical insurance dependents are tobacco free, according to the definition above, or agree to enroll in a cessation program, you qualify for tobacco-free discount rates. If you selected a different response, you are eligible for the non-discount rates.
  - Your contributions for the medical, dental, vision, life insurance (2x salary), and long-term disability (Buy-up Plan) plans are deducted on a before-tax basis, unless you are exempt from federal or state taxes or specifically elect otherwise.
  - After the initial enrollment, if you want to change how you pay your share of the benefit costs from an after-tax to a before-tax basis, or vice versa, you can only do so during the Annual Enrollment change period.
- Changes must be submitted to your Total Rewards Generalist (TRG) within 31 days from the date of the event. TRG Contact information is located on page 2.
- Proof of relationship documentation must be submitted to your TRG within 31 days from the date of the event. Dependents added to the plan due to a loss of coverage will need to provide proof of coverage loss in addition to proof of relationship within 31 days from the dates of the event.
- Changes to other benefit elections may have specific requirements or restrictions and must be consistent with the Family Status change. Please contact TRG for details on changes to benefits other than medical, dental, or vision.
- Read, sign and date the Authorization and Acknowledgements (section IV), prior to returning this form to your TRG. Please be sure to make a copy for yourself.

I. FAMILY STATUS CHANGE: Effective Date of Change: _____

☐ Add coverage due to:	☐ Cancel coverage due to:	DEPENDENT NAME CHANGES ONLY
☐ Marriage/Divorce ☐ Spouse loses other medical coverage ☐ Spouse's coverage was University of Missouri coverage ☐ Spouse's employer discontinues coverage or significant change in coverage ☐ Birth/Adoption ☐ Child/ren lose other coverage ☐ Child/ren of new spouse ☐ Employee loses other coverage through: _____	☐ Death ☐ Divorce/Legal separation ☐ Termination of Sponsored Adult Dependent Partnership (must complete affidavit of termination) ☐ Dependent becomes ineligible ☐ Spouse obtains other health coverage ☐ Spouse's coverage is University of Missouri coverage ☐ Child obtains other health coverage	_____ Current first & last name _____ New First & Last Name Effective Date of Change:____/_____/_____ *Additional documentation required, please contact your TRG.

II. DEPENDENT INFORMATION: Complete the following information for any dependent(s) to be added or cancelled.

Dependent/Spouse Name	Relationship Spouse/SAD*** Child	Gender M/F	Birth date (MM.DD.YY)	Social Security Number	ADD**** Medical	ADD**** Dental	ADD**** Vision	ADD**** Life	REMOVE Medical	REMOVE Dental	REMOVE Vision	REMOVE Life

*** If you enroll a Sponsored Adult Dependent (SAD) on your plan, you will also need to complete an Affirmation.
****If you are adding a dependent to your insurance, you will be required to provide Proof of Relationship (POR).

*Evidence of insurability is required. Applicable forms may be obtained from http://umurl.us/benforms.

III. ENROLLMENT OPTIONS: Please indicate only the plan option(s) you are electing. If there is no change in a plan selection, please leave the section blank.

Medical Insurance

NON-DISCOUNT RATES

Pre-tax unless this box is checked for an after-tax contribution ☐

Medical	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Healthy Savings Plan**	☐ (37) $85.00	☐ (38) $170.00	☐ (40) $145.00	☐ (41) $238.00
Custom Network Plan (Columbia area)	☐ (49) $123.00	☐ (50) $246.00	☐ (52) $209.00	☐ (53) $344.00
Custom Network Plan (St. Louis area)	☐ (85) $123.00	☐ (86) $246.00	☐ (88) $209.00	☐ (89) $344.00
PPO Plan	☐ (61) $201.00	☐ (62) $402.00	☐ (64) $342.00	☐ (65) $563.00

**If you enroll in the Healthy Savings Plan, you will also need to complete the HSA Enrollment Form

DISCOUNT RATES

Pre-tax unless this box is checked for an after-tax contribution ☐

Medical	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Healthy Savings Plan**	☐ (01) $35.00	☐ (02) $120.00	☐ (04) $95.00	☐ (05) $188.00
Custom Network Plan (Columbia area)	☐ (25) $73.00	☐ (26) $196.00	☐ (28) $159.00	☐ (29) $294.00
Custom Network Plan (St. Louis area)	☐ (73) $73.00	☐ (74) $196.00	☐ (76) $159.00	☐ (77) $294.00
PPO Plan	☐ (13) $151.00	☐ (14) $352.00	☐ (16) $292.00	☐ (17) $513.00

**If you enroll in the Healthy Savings Plan, you will also need to complete the HSA Enrollment Form

WAIVE MEDICAL COVERAGE

Decline ☐ (W) waive – Please indicate reason for waive below

☐ other coverage ☐ unaffordable ☐ religious reasons ☐ not interested

Dental and Vision Insurance

Pre-tax unless this box is checked for an after-tax contribution ☐

Dental	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Dental Plan	☐ (01) $14.76	☐ (02) $29.52	☐ (03) $35.82	☐ (04) $50.58
Decline	☐ (W) waive			

Pre-tax unless this box is checked for an after-tax contribution ☐

Vision	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Vision Plan	☐ (01) $5.88	☐ (02) $11.73	☐ (03) $12.80	☐ (04) $20.26
Decline	☐ (W) waive			

*Evidence of insurability is required. Applicable forms may be obtained from http://umurl.us/benforms.

Disability and Life Insurance

Option B is pre-tax unless this box is checked for an after-tax contribution ☐

Basic life	Option A (1 x base salary & age graded)	Option B (2 x base salary & age graded)
Basic life insurance	☐ (01) $0.00	☐ (02) $0.03 per $1,000 of coverage
Decline	☐ (W) waive	

After-tax Contribution

AD&D	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
AD&D – Self	☐ (01) $0.53	☐ (02) $1.05	☐ (03) $1.58	☐ (04) $2.10	☐ (05) $2.63	☐ (06) $3.15
AD&D – Family	☐ (07) $0.73	☐ (08) $1.45	☐ (09) $2.18	☐ (10) $2.90	☐ (11) $3.63	☐ (12) $4.35
Decline	☐ (W) waive					

After-tax Contribution (rates will vary based on age)

Supplemental Life*	Supplemental life options are 1, 2 or 3 times your annual base salary. You may elect or increase your supplemental life coverage. Please request the applicable form from your Total Rewards Generalist.

	After-tax Contribution (rates will vary based on age)				
Spouse Life	$10,000	$20,000	$30,000*	$40,000*	$50,000*
Spouse	☐ (01)	☐ (02)	☐ (03)	☐ (04)	☐ (05)
Decline	☐ (W) waive				

	After-tax Contribution				
Dependent Life Child/ren	$5,000	$10,000*	$15,000*	$20,000*	$25,000*
Dependent Life Child/ren	☐ (01) $0.35	☐ (02) $0.70	☐ (03) $1.05	☐ (04) $1.40	☐ (05) $1.75
Decline	☐ (W) waive				

	Option B is pre-tax unless this box is checked for an after-tax contribution ☐	
Long Term Disability	Core Plan (Option A)	Buy-up Plan (Option B)*
Long Term Disability	☐ (01) $0.00	☐ (02) $0.20 per $100 of monthly income

IV. AUTHORIZATION AND ACKNOWLEDGEMENTS:

I hereby make the above elections and I authorize the University of Missouri to deduct/redirect the appropriate amounts from my pay for the coverages elected. (I also hereby authorize the appropriate providers to release any documentation necessary to pay my or my dependents' claims.)

I acknowledge, that in the event that I or any of my dependent/s become ineligible for coverage under the Plan, it is my responsibility to inform the University of Missouri System's Office of Human Resources of desired changes in coverage and/or changes in my family status or personal information that affects my benefit coverage or eligibility by completing an enrollment change form within 31 days of the event. (I also understand that any claims paid on behalf of an ineligible individual must be reimbursed to the Plan by me.)

_____ _____ _____

Employee ID **Signature of Employee** **Date**

*Evidence of insurability is required. Applicable forms may be obtained from http://umurl.us/benforms.

Availability of Summary Health Information

As a University of Missouri employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC, along with a uniform glossary of terms commonly used in health care coverage, is available on the web at: http:/umurl.us/SBC. Paper copies are also available, free of charge, by calling the HR Service center at 1-800-488-5288.

*Evidence of insurability is required. Applicable forms may be obtained from http://umurl.us/benforms.