University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

2018 Benefits Change Form

Tobacco Attestation

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 2018 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 prior to January 1, 2018, or your medical coverage effective date*, and will not use tobacco products through December 31, 2018.
- “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, 2018, to June 30, 2018, enrollment in a tobacco cessation program is required. I understand that to continue the tobacco-free premium discount for the second half of 2018 (from July 1, 2018, to December 31, 2018) I must complete another attestation by June 30, 2018, 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 System, 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 local campus contact (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 local HR campus contact, 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, 2018, or after:**
If I enroll in medical insurance coverage after the Annual Enrollment period with an effective date on or after January 1, 2018, I understand that I may participate in the tobacco-free premium discount through December 31, 2018. 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.

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 UM System 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.

____ ____________________

Employee Name **Employee ID**

____ ____________________

Employee Signature **Date**

University of Missouri System

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2018 Benefits Change Form

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 Section I, Family Status Change, complete Sections I, II, III and IV.
- Make your benefit selections (Section I)
  - o Your contributions for the medical, dental, vision, basic life insurance option B (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.
  - o 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.
- The change form must be submitted to your local campus contact within 31 days from the date of the event. Campus contact information is located on the last page of this document.
- Proof of relationship documentation must be submitted to your campus contact 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 your campus contact for details on changes to benefits other than medical, dental or vision insurance.
- Read, sign and date Section IV, the Authorization and Acknowledgements, before returning this form to your local campus contact. Please make and keep a copy for your records.

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 makes 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 consult your local HR campus contact.

II. Dependent Information

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

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

III. Enrollment Options

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**	☐ (01) $88.00	☐ (02) $176.00	☐ (04) $150.00	☐ (05) $248.00
Custom Network Plan (Columbia area)	☐ (25) $128.00	☐ (26) $256.00	☐ (28) $219.00	☐ (29) $361.00
Custom Network Plan (St. Louis area)	☐ (73) $128.00	☐ (74) $256.00	☐ (76) $219.00	☐ (77) $361.00
PPO Plan (includes Tiered PPO for UMKC)	☐ (13) $213.00	☐ (14) $426.00	☐ (16) $365.00	☐ (17) $601.00

**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) $38.00	☐ (02) $126.00	☐ (04) $100.00	☐ (05) $198.00
Custom Network Plan (Columbia area)	☐ (25) $78.00	☐ (26) $206.00	☐ (28) $169.00	☐ (29) $311.00
Custom Network Plan (St. Louis area)	☐ (73) $78.00	☐ (74) $206.00	☐ (76) $169.00	☐ (77) $311.00
PPO Plan (includes Tiered PPO for UMKC)	☐ (13) $163.00	☐ (14) $376.00	☐ (16) $315.00	☐ (17) $551.00

**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) $5.59	☐ (02) $11.15	☐ (03) $12.17	☐ (04) $19.26
Decline	☐ (W) waive			

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

Accidental Death and Dismemberment	$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 local HR 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				

*$10,000 and $20,000 amounts are guaranteed approval only if being added due to a new marriage or loss of University of Missouri coverage. All other situations require evidence of insurability (EVI). EVI forms may be obtained online at http://umurl.us/benforms.

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

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				

*$5,000 amount is guaranteed approval only if being added due to birth, adoption or child(ren) of new spouse. All other situations require evidence of insurability (EVI). EVI forms may be obtained online at http://umurl.us/benforms.

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

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

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**

Availability of Summary Health Information

As an employee of University of Missouri System, 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.

Campus Contact Information

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

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

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

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