

Delta Dental

The University of Mississippi offers dental benefits through enrollment with Delta Dental Insurance Company. Two plan options are available with this dental plan: low option and high option. Both options offer similar benefits for diagnostic/preventive, basic and major services. Assigned co-insurance, annual limits, and monthly premiums will vary depending on the option elected. A brief overview of each option is provided in the following benefits summary. A more detailed description of benefits is available in the dental flyer and policy book which can be accessed at <http://www.olemiss.edu/hr/benefits.html>.

Coverage Options & Premiums

The following features are available under both options:

- **SEE ANY DENTIST**
- **\$50 DEDUCTIBLE/MEMBER/CALENDAR YEAR**
- **\$150 FAMILY DEDUCTIBLE/CALENDAR YEAR**
- **DIAGNOSTIC AND PREVENTIVE SERVICE (D&P) PAID AT 100% OF USUAL AND CUSTOMARY RATES (NOT SUBJECT TO DEDUCTIBLE) WHEN USING PPO OR DELTA PREMIER DENTIST (A LIST OF PROVIDERS IS AVAILABLE @ www.deltadentalins.com).**

Low Plan Option

The low option may be appropriate for employees who require minimal dental services. This option offers benefits with lower co-insurance for basic and major services at a lower monthly premium. Please note orthodontic benefits are unavailable.

<i>Benefits Summary</i>	Co-insurance Payable on the UCR
Basic Diagnostic and Preventative Benefits: Procedures to assist the dentist in determining required dental treatment (oral examinations, x-rays, emergency office visits); prophylaxis (cleaning); topical application or fluoride solutions and space maintainers twice a year.	100% (No Deductible)
Restoration, Denture Repairs, and Other Basic Services: Amalgam, synthetic porcelain, fillings, procedures for the repair of partial or complete dentures and sealants, oral surgery, and general anesthesia when administered by a dentist for a covered oral surgery procedure.	50% After Deductible
Periodontics/Endodontics, Crowns/Prostodontics: 12-month waiting period Treatment of gums supporting the teeth and the treatment of tooth pulp/root canal therapy. Crowns and cast restoration for treatment of carious lesions when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations; and procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.	25% After Deductible
Orthodontic Benefits:	Not available

Calendar year maximum:	Per patient	\$1,000
Monthly Rates:	<u>12-Month</u>	<u>9-Month</u>
Individual	\$26.84	\$35.79
Family	\$56.00	\$74.67

High Plan Option

The high option offers benefits to employees with a greater need for major dental work or orthodontic benefits.

<i>Benefits Summary</i>	Co-insurance Payable on the UCR
Basic Diagnostic and Preventative Benefits: Procedures to assist the dentist in determining required dental treatment (oral examinations, x-rays, emergency office visits); prophylaxis (cleaning); topical application of fluoride solutions and space maintainers twice a year.	100% (No Deductible)
Restoration, Denture Repairs, and Other Basic Services: Amalgam, synthetic porcelain, fillings, procedures for the repair of partial or complete dentures and sealants, oral surgery, and general anesthesia when administered by a dentist for a covered oral surgery procedure.	80% After Deductible
Periodontics/Endodontics, Crowns/Prostodontics: 12-month waiting period Treatment of gums supporting the teeth and the treatment of tooth pulp/root canal therapy. Crowns and cast restoration for treatment of carious lesions when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations; and procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.	50% After Deductible
Orthodontic Benefits: children under age 19 (12-month waiting period)	50% After Deductible

Calendar year maximums:	Per patient	\$1,500
	Lifetime Orthodontic-per patient	\$1,200
Monthly Rates:	<u>12-Month</u>	<u>9-Month</u>
Individual	\$38.72	\$51.63
Family	\$80.56	\$107.41

Employees electing to enroll in coverage as a new participant, change plan option, add or drop dependents, or cancel existing coverage are required to make elections through the myOleMiss Open Enrollment portal and 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 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 dental 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 1 – Provide information for spouse and children who will be covered under this policy.
- Page 1 – Complete the section designated for **Delta Dental**.
Select coverage option by marking the box that corresponds to the tier (employee only or family) and plan type (low or high). Answer 'other coverage' questions.
- Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form.

Add or Drop a Dependent to Existing Coverage

Employees adding a spouse or child(ren) to their existing vision coverage 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 1 – Provide information for spouse and children who will be add to this policy.
- Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form

If the addition or removal of a family member changes your coverage type, then select the new coverage option by marking the box that corresponds to the tier (employee only or family) and plan type (low or high).

Change Plan Option

Employees who wish to change their coverage from the High Plan to Low Plan or Low Plan to High 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 1 – Complete the section designated for **Delta Dental**.
Select coverage option by marking the box that corresponds to the tier (employee only or family) and plan type (low or high) reflecting the new coverage.
- Read ***Cafeteria Plan (Section 125 Plan) Certification and Payroll Deduction Authorization***
- Sign and date the form

Cancellation of Existing Coverage

Employees cancelling dental coverage must print a copy of the ***Open Enrollment Benefits Confirmation*** available on the Open Enrollment homepage, write DROP next to Delta Dental, sign and date the form and return it to the Human Resources office with other Open Enrollment paperwork.



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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Status: <input type="checkbox"/> 9-Month <input type="checkbox"/> 12-Month	Pay Mode: Semi-Monthly	Marital Status:	
Check One: <input type="checkbox"/> New Hire <input type="checkbox"/> Legal Marriage/Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Status Change _____ <input type="checkbox"/> 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

<p style="text-align: center;"><u>Employee Only</u></p> <p>Low Plan (division: 00002) <input type="checkbox"/> <u>12-month / 9-month</u> \$26.84 / \$35.79</p> <p>High Plan (division: 00001) <input type="checkbox"/> \$38.72 / \$51.63</p>	<p style="text-align: center;"><u>Family</u></p> <p><input type="checkbox"/> <u>12-month / 9-month</u> \$56.00 / \$74.67</p> <p><input type="checkbox"/> \$80.56 / \$107.41</p>
---	--

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

<p style="text-align: center;"><u>12-month / 9-month</u></p> <p>Employee Only <input type="checkbox"/> \$7.80 / \$10.40</p>	<p style="text-align: center;"><u>12-month / 9-month</u></p> <p>Employee + 1 <input type="checkbox"/> \$14.08 / \$18.77</p>	<p style="text-align: center;"><u>12-month / 9-month</u></p> <p>Family <input type="checkbox"/> \$21.89 / \$29.19</p>
--	--	--

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

	<u>Employee Only</u>	<u>Family</u>
	<u>12-month / 9-month</u>	<u>12-month / 9-month</u>
Low Option - no Intensive Care (CP10A)	<input type="checkbox"/> \$ 9.40 / \$12.52	<input type="checkbox"/> \$15.50 / \$20.64
High Option - no Intensive Care (CP10B)	<input type="checkbox"/> \$14.98 / \$19.96	<input type="checkbox"/> \$25.82 / \$34.40
Low Option - \$300/day Intensive Care (CP10A / ICR2)	<input type="checkbox"/> \$12.40 / \$16.52	<input type="checkbox"/> \$21.49 / \$28.64
High Option - \$300/day Intensive Care (CP10B / ICR2)	<input type="checkbox"/> \$17.98 / \$23.96	<input type="checkbox"/> \$31.81 / \$42.40
Low Option - \$600/day Intensive Care (CP10A / ICR2)	<input type="checkbox"/> \$15.39 / \$20.52	<input type="checkbox"/> \$27.49 / \$36.64
High Option - \$600/day Intensive Care (CP10B / ICR2)	<input type="checkbox"/> \$20.97 / \$27.96	<input type="checkbox"/> \$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 _____