

Enrollment Guidelines: 2024-2025

Why is open enrollment so important?

Benefits open enrollment for Southern Utah University is held each year. Employees should understand that the pre-tax payment for applicable benefits is done through the Cafeteria plan and, as noted above, under IRS regulations elections cannot be revoked or changed during the plan year. **Once the enrollment period has ended, employees may not make or change benefit elections unless they experience a qualifying event.** Employees must notify Human Resources of any change of status as soon as possible, but generally within **30 days** after the event.

Who is eligible to participate in the benefit plans?

- Employees in a benefit eligible position who work 30+ hours per week;
- Employees' legally married spouse, and/or dependent(s), (dependents are generally children who are less than 26 years of age); see your Benefits Summary's definition of legally married spouse and/or dependent(s);

When do benefits begin?

- Eligible employees can receive benefits on date of hire. Life and Disability coverage begins first of the month following date hire (provided forms are properly submitted);
- Employees hired after the plan year begins will select their coverage choices for the remainder of that plan year at the time of eligibility. All the necessary enrollment and change forms are available through the Human Resources department.

Is it possible to make changes during the year?

After the enrollment deadline, your election is generally irrevocable, meaning you cannot add, modify, or drop coverage for the plan year. You may have a special enrollment right allowing coverage changes for certain losses of coverage eligibility under another plan, or if you gain a new spouse or dependent. You also may be entitled, or required, to change your election if you, your spouse, or dependents experience one of the qualifying change events listed in the next section. However, you must contact Human Resources to determine if your plan and circumstances allow such a change. If so, you must complete and return a change form to Human Resources generally within 30 days.

Qualifying Changes: (30 Days Unless Otherwise Stated Below)

- Marriage, divorce, or legal separation;
- Change in number of dependents (e.g., Birth or adoption of a child or another change in the number of dependents);
- Change in employment status of employee, spouse, or dependent that causes loss of eligibility;
- Dependent ceases to satisfy eligibility requirements;
- Change in residence that causes loss of eligibility;
- Significant changes in company benefit plan(s), including cost change, significant coverage curtailment, additional or significant improvement of company offered benefits;
- Change in coverage under another employer plan (including mandatory or optional change initiated by your spouse's employer or a change initiated by your spouse);
- Loss of coverage from government plans/programs or educational institution;
- COBRA qualifying event (termination/reduction of hours, employee death, divorce/legal separation, ceasing to be a dependent);
- Other changes resulting from a judgment, decree, or order;
- Medicare or Medicaid entitlement;
- FMLA leave of absence;
- Loss or gain of CHIP or Medicaid subsidy eligibility (60 Days)

Glossary of Terms

Co-pay: Typically refers to a fixed dollar amount a member must pay for a particular service (such as a physician visit or ER visit).

Deductible: Amount that must be paid by the member before an insurance carrier will pay a claim; benefits offered after deductible are indicated with AD.

Coinsurance: Typically refers to a member's share of covered costs after any deductible has been satisfied.

Out of Pocket Maximum (OOPM): The maximum amount members pay for covered network essential health benefit expenses during the benefit year, including co-pays, coinsurance, and deductibles.

PPO (Preferred Provider Organization): This type of plan utilizes both network and non-network benefits.

Network (In-Network): Providers who have agreed to accept contracted rates from an insurance carrier.

Non-Network (Out of Network): Any non-contracted providers. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.

Health Maintenance Organization (HMO): This plan covers in-network providers and services only; it does not cover any out of network services.