

B/P/P Operations Center

Insurance - Frequently Asked Questions

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Insurance Frequently Asked Questions of BPP OC

1. What is the standard format for entering names in the B/P/P System?

On a weekly and/or monthly basis, benefit information is sent to the insurance plan carriers. Having names that do not follow the standardized name format convention results in bad data being passed along to the carriers. This will also cause mismatches later when claims are filed, resulting in participant displeasure with the plan administrators and benefits offices as claims are denied and have to be appealed.

The standardized format by which names should be entered follows. This includes all names, be it an employee, retiree, COBRA participant, dependents, etc.

The names entered into the B/P/P System on Screens 051, 101 and 115 should match the names as entered on a Social Security card. The last name should be entered in the last name field on the B/P/P System, with imbedded spaces if necessary. The first name(s) should be entered in the first name field on the B/P/P System and, if present, the middle initial or first character of the middle name entered in the middle initial field on the B/P/P System. A suffix (for example, a JR (junior) or III (the third)), should be entered in the suffix field on the B/P/P System. The B/P/P System will generate a combined name in a single field based on the names entered above.

There are some individuals with only one name. In these cases, the name should be entered in the LAST name field.

When there is a change in a name field, the B/P/P System will automatically compare the changed name with the A&M System's Universal Identification Number (UIN) System. This system has been developed to maintain a central repository for all individuals affiliated in some manner with the A&M System. It provides a positive method of uniquely identifying individuals using a number other than the Social Security Number. You will be prompted to verify that the name for the individual has been changed and that the name you just entered is correct. Please follow the instructions and carefully enter the correct name as requested in the appropriate fields. This will help maintain the integrity of the data in the UIN system.

2. What is the proper way to delete dependents?

Dependents are not usually deleted. If a dependent is no longer covered, the flags should be set to 'N' and a Stop Date should be entered. If it is necessary to delete the dependent, such as mistakenly entering the wrong dependent at Annual Enrollment, then the dependent flag should be set to 'N' along with entering a dependent stop date. Once the first Wednesday of the month has passed, the dependent can then be blanked out entirely from the Screen. Waiting until after the first Wednesday will allow the dependent stop record to be sent to the carrier.

3. What should I do if I get the message "Invalid Med Start Date" when trying to change medical carriers?

A new start date is required when changing Medical Carriers. The dependent start dates should also be changed. The new start date is sent to the carrier and identifies when coverage began for the participant. There are situations where you do not want to change the start date, such as a new employee who changed carriers. Working around the edit can be done by typing in a new start date, updating the database, and going back and re-entering the initial start date.

4. What is the difference between the Budgeted Salary, the FTE Salary, the Optional Life Salary and the Benefit Salary?

The Budgeted Salary is generally defined as being the salary the employee will receive during the fiscal year. The FTE Salary is the salary that would be paid if the employee is paid full time (100% effort) over 12 months. For most staff employees, these values are the same. Faculty and Part-timers will be different.

For Example: A nine-month faculty member being paid \$1,000 per month would have a Budgeted Salary of \$9,000 and an FTE Salary of \$12,000.

$$\begin{aligned} & \$1000 / \text{month} * 9 \text{ months} * 100\% = \$9000 \text{ (Budgeted Salary)} \\ & \$1000 / \text{month} * 12 \text{ months} * 100\% = \$12,000 \text{ (FTE or annualized Salary)} \end{aligned}$$

An employee that is budgeted for 12 months, but only works 50% time with a full time salary of \$1000 per month, would have a Budgeted Salary of \$6000 and an FTE Salary of \$12,000.

$$\begin{aligned} & \$1000 / \text{month} * 12 \text{ months} * 50\% = \$6000 \text{ (Budgeted Salary)} \\ & \$1000 / \text{month} * 12 \text{ months} * 100\% = \$12,000 \text{ (FTE or annualized Salary)} \end{aligned}$$

The Optional Life Salary (OL-SAL) is used to calculate coverage amounts for Optional Life and Alternate Basic Life Insurance coverage. This salary is updated annually with the processing of the Fiscal Year Initialization (Insurance Initialization). In processing OL-SAL, the greater of the current OL-SAL or the FTE Salary is multiplied by the percent of effort.

Using our previous example of the employee that is budgeted for 12 months, but only works 50% time, the OL-SAL calculation would look like this:

$$\$12,000 * 50\% = \$6000 \quad (\$12,000 \text{ is used because it is the greater of the two})$$

ADD and LTD coverage are based on the Benefit Salary. The Benefit Salary is defined as the Budgeted Salary, as of September 1st of each year, OR the previous Benefit Salary, whichever is greatest. ADD and LTD coverage are calculated annually as well. Should an employee's actual salary change during the fiscal year, the amount deducted for this coverage will stay the same until the next calculation period (September 1st of each year).

5. How do you know if someone is eligible for the State Group Insurance Payment (SGIP) - the Employer's Contribution toward insurance premiums? Why are there so many codes?

An employee is eligible for the State's Contribution for Insurance Premiums (SGIP) if they work or are budgeted to work at least 50% effort for 4 ½ months or more. Most Retirees and those on Family Medical leave are also eligible.

The payment of the state's contribution is controlled by the priority code on the BE Screen in the Personnel Database. A numerical priority code on an active insurance coverage indicates that a state contribution toward the payment of the benefit premium may be made. The priority code also indicates the order in which the state's portion of the money will be applied. For example, a person that has...

Medical Coverage – the state money will only pay towards Basic Life (BL) and Medical Coverage (MED). Priority Codes should be set to 1 and 2 respectively.

A QUICK REFERENCE to follow:

Benefit Eligible – an employee that is eligible to receive the state's contribution toward insurance premiums.

Certification of other medical coverage – If an employee/retiree certifies that they have other medical coverage, an 'O' (the letter O) should be entered in the medical deduct code. The state contribution may then be used to pay premiums such as Alternate Basic Life (BL), Dental (DEN), Vision (VIS), Accidental Death and Dismemberment (ADD) and Long-Term Disability (LTD), based on the SGIP priority codes.

SGIP-ELIG-CD – is used to identify employees who are benefit eligible. Depending on the benefit programs that the employee enrolls in, this code in and of itself will show whether or not the employee is eligible to receive the state's contribution toward insurance premiums. If the employee/retiree is eligible for the state contribution, this code will be the same as their insurance deduction codes on Screen **106** in the Personnel Database. An 'E' will be coded if the person does not have any insurance premiums but is SGIP eligible. Otherwise, SGIP-ELIG-CD should be coded with an 'N'. A '?' in this field means the data entry for this individual is incomplete.

SGIP-ELIG-CD is used in the select criteria to determine who is to be included on certain reports, mailing lists, etc.

6. On Screen 106 in Personnel Maintenance, there is a change date associated with the various types of insurance benefit coverage. When should this date be changed and what should it be?

The change date field has different meanings and impacts depending on the type of coverage. **Change dates are crucial because they are reported to the carrier as the effective date for a participant's coverage, termination of coverage, or change in status.**

Basic Life – will require a change date if the coverage amount changes or if the employee becomes a retiree.

Medical – If a change occurs in any of the following fields: **Plan, Carrier, Medicare, Family Status, or Number Covered**, BPP will automatically enter a change date (the first of the following month), unless the HR office manually enters another date.

A change date **MUST** also be entered whenever the deduction code changes from a '1', '2', '3', 'L', or 'M' to a **retiree deduction code of 'R' or '4'**.

If the carrier code is '01' (TAMUS indemnity carrier), the participant has moved from a network to a non-network benefit status. HMO's require no change date as the participant will not experience any change in benefits or service.

Example: If an employee has a newborn on February 20, 1995, and adds the newborn to their coverage within 31 days, the change date for medical coverage on Screen **106** should read **02201995**. If a change date is not entered on Screen 106, BPP will automatically enter a change date of 03011995 (the first of the following month). **The change date becomes the effective date for the newborn's coverage and is crucial in receiving benefits.**

If the change of status is not entered into the system until March 23, one day past the specified 31 day grace period, AND the change date was NOT entered on Screen 106, the newborn's coverage would not begin until 04011995.

AD&D: For an enrolling participant, the change date should match the start date. For a dependent being added or dropped, the change date should be the first day of the following month. For an employee that is changing from individual coverage to family coverage, the change date should be on the first day of the following month. For an employee changing the amount of coverage, either increasing it or decreasing it, the change date should be on the first day of the following month. Any changes made during annual enrollment, BPP will automatically enter a change date to reflect the first day of the new fiscal year.

Dental: For an enrolling participant, the change date should match the start date. For a dependent being added or dropped, the change date should be the first day of the following month. A change in the family status and number covered will generate a change date. An active employee becoming a retiree will generate a change date.

Dependent life: For an enrolling participant, the change date should match the start date. For a dependent being added or dropped, the change date should be the first day of the following month. For a change in coverage, or if the employee becomes a retiree,

the change date should be the first day of the following month.

- LTCE:** A change in the coverage amount will generate a change date.
- LTCS:** A change in the coverage amount will generate a change date.
- LTD:** Whenever there is a change to the coverage amount, the smoker flag changes, or the employee becomes a retiree, BPP will automatically enter a new change date to reflect the first day of the following month, unless the HR office manually enters another date.
- Optional Life:** For an enrolling participant, the change date should match the start date.
- For a mid-year plan change, the change date should be on the first day of the following month upon the date of approval from the insurance carrier.
Change dates must reflect the first day of the month. No other date should be used.
During annual enrollment, BPP will automatically enter a new change date to reflect the beginning of the new fiscal year.
- Whenever there is a change to the coverage amount, the smoker flag changes, or the employee becomes a retiree, BPP will automatically enter a new change date to reflect the first day of the following month, unless the HR office manually enters another date.
- Vision:** For an enrolling participant, the change date should match the start date.
For a dependent being added or dropped, the change date should be the first day of the following month.
A change in the family status and number covered will generate a change date.
An active employee becoming a retiree will generate a change date.

Other Issues

- COBRA:** The change date should reflect the first day of the month after the active coverage ends. The change date is used as the effective date, or start date, for COBRA. Incorrect COBRA start dates will affect the COBRA participant's billing. If the change date is not correct, the stop date of 18 or 36 months later will also be wrong.
- DEATH:** The change date should reflect the day following the date of death. The stop date should reflect the actual date of the participant's death. If the employee has dependent coverage, the stop date would be the last day of the month in which the death occurs. The change date would then follow as the first day of the following month.

- TERMINATIONS:** Termination dates for all coverage should reflect the last day of the month in which the participant terminates.

The change date should be the first day of the month following the termination date.

7. An employee has a family status change that results in a change in premiums. How should this be handled?

Insurance premiums are always based on a monthly period. A full month's premium will have to be deducted for the month in which the change occurs, regardless of the date of the change. The critical point is for the employee to define when the change is to take effect.

The options for when the change may be effective are basically (1) effective the date of the family status change or (2) effective the first of the month following when the change form is returned to the appropriate benefits office, given the form is returned within 31 days of the family status change. For example, if an employee has a family status change on May 20, he may choose to have the new benefits and premiums take effect on May 20 (new premium for the entire month of May), June 1 (with form submitted by May 31) or July 1 (with form submitted by June 20th, the 31st day after the family status change). The premium due date will have to be set to the first of the month. CAUTION: For biweekly employees, the full employer amount is always deducted from the first biweekly payroll. The employee portion is split between two payrolls. If the first biweekly payroll has already processed for a month, the due date should be set to the 1st and a cancellation should be done on the employer payment amount, if one exists.

8. What insurance benefit deduction payment options are available to an employee who has had their 9 month contract extended through the summer and will now be working a full year?

The ideal situation is that the employee knows about the summer appointment before their May paycheck is calculated. In that case, simply change their deduct code to a '2'.

If during the school year their code was a '1', then it must be changed to a '2' before their May paycheck is calculated.

If their deduct code was a '3', then it may be changed to a '2' anytime before May month-end processing.

For those employees who find out about a summer appointment after the May month end, the best and most highly recommended course of action is to leave the deduction code as it was (either '1' or '3') for the remainder of the summer. If their deduct code is a '3', they will be billed for their premiums. If their deduct code is a '1', then their premiums will be deducted on a pre-tax basis.

Any changes to the deduction codes after May month-end will cause the employee's records to be out of synchronization with each other. If it is necessary

to adjust their billing status for the summer appointment, then the schedule below will need to be followed.

If the employee received an appointment for the **whole summer**:

Before the first June pay calculation,
change their deduct code(s) to a '2',
change the premium due dates to June 1,
delete all of the summer GIP sources, and
do not send their June bill if it was printed

If the employee receives an appointment for the **first summer semester only**:

After May month end, but before the first June Pay calculation,
change their deduct code(s) to a '2',
change the premium due dates to June 1,
delete their June and July SGIP sources, and
do not send their June bill if it was printed

AND...

Before the July insurance billing process, manually request a bill for August premiums,
change their deduct code(s) to a '2' and
delete their July and August SGIP sources

9. What do I do with a 9-month employee who is retiring at the end of May and is on the Extended Pay Plan (EPP)?

The insurance deduct codes will be a '1' and 4 months of summer premiums were to be deducted in May. To prevent 4 months of insurance deductions from being taken out, the EPP deduct code must first be changed to an 'N'. The insurance deduct codes should then be changed from a '1' to a '2'. This should be done *before* the May monthly payroll calculation.

Immediately after monthly payroll calculation, the insurance deduct codes should be changed to an 'R', before BILL0001 is run. BILL0001 will usually run the next day following payroll calculation. This will allow the person to be billed for the month of June. NOTE: This is for monthly paid employees only.

10. When should I use the Transcribe function?

The Transcribe function on the Personnel Database menu copies the record in the file from one Social Security Number to another. The transcribe function may be used when:

An incorrect SSN was entered (see Payroll Frequently Asked Questions
A person becomes a survivor. In order to avoid any billing information being copied over, the employee status code should be a 'D' on the record you are copying from.

Be sure to adjust all deduction codes on both the old and the new record as appropriate and needed to insure proper deductions or bills are generated.