HEALTH CARE AND DENTAL COVERAGE ENROLLMENT FORM

THE UNIVERSITY OF UTAH

Employee Name		Employee ID #	
Address	City	State	Zip Code
Email Address	Home Phone	Work Phone	

I experienced the following event during the past 90 days:

[ ] New Hire
[ ] Loss of Other Coverage: Date _____
[ ] Transferred to a Benefit-Eligible Position from an Ineligible Position
[ ] Moved from a Part-time (50-74% FTE) to Full-Time (75%+ FTE) Position

HEALTH PLAN CHOICES *(Choose one option in each box below)*:

Plan Design	Network	Dental Coverage	Coverage Level
[ ] Advantage [ ] Comprehensive [ ] CDHP * *(Preferred ValueCare Network Only)*	[ ] BlueCross BlueShield (PAR) [ ] Preferred ValueCare	[ ] Yes [ ] Waive	[ ] Single Coverage [ ] Two-Party Coverage [ ] Family Coverage

***The Consumer Directed Health Plan (CDHP) includes providers in the Preferred ValueCare network. The CDHP design option may be combined with a Health Savings Account (HSA) by completing a separate HSA enrollment form.**

Dependents to be Enrolled	Name (First, Middle, Last)			Address (If different from employee's address)	Relationship	Social Security Number	Birthdate Month/Day/Year
Spouse					[ ] Husband [ ] Wife		
Eligible Children (See definition of eligible children on reverse side of this form)					[ ] Daughter [ ] Son		
					[ ] Daughter [ ] Son		
					[ ] Daughter [ ] Son		
					[ ] Daughter [ ] Son		
					[ ] Daughter [ ] Son		
					[ ] Daughter [ ] Son		

Certification

I have read and I agree to the conditions contained on the back of this form. I understand I may enroll in health care coverage within 90 days of my date of hire or transfer into a benefit-eligible position from a non-eligible position, during Open Enrollment, or if I experience an event that results in a special enrollment period for me. I also understand that I may not change or cancel these elections until Open Enrollment, unless I experience a qualified status change event (as defined by the Internal Revenue Code) consistent with the requested change and submit the completed paperwork to the Benefits Department within **90 days** of the event. If at any time I participate in unpaid leave under the Family & Medical Leave Act (FMLA), I authorize the University to deduct any unpaid contributions retroactively upon my return. I understand if my FTE drops between 50-74%, I will automatically be charged the part-time rate, and must notify the Benefits Department within 90 days if I wish to cancel coverage or drop enrolled dependents (the change to my contribution rate will not be retroactive). I understand if my FTE drops below 50%, I will no longer be eligible and my coverage will be terminated. I agree to notify the Benefits Department if one of my listed dependents ceases to qualify as an eligible dependent or if the address of one of my dependents changes. I hereby authorize payroll deductions of contributions on a pre-tax basis as required.

I certify the information I have provided on all parts of this form is true and correct. I understand that if I knowingly file a statement of claim for an individual who does not qualify as an eligible dependent or otherwise containing any misrepresentation or any false, incomplete, or misleading information I may be subject to adverse employment action up to and including termination, my coverage may be cancelled without the right to elect COBRA, and I may be guilty of a criminal act punishable under law and subject to civil penalties.

Employee Signature: _____ Date: _____

Benefits Dept Use Only:	Entry Date:	Entered By:	QC By:	QC Date:

Statement of Understanding and Agreements

HEALTH AND DENTAL COVERAGE

As an employee in a benefit-eligible position, I may enroll in the University of Utah Employee Health Care Plan medical and dental options within 90 days of the date I am hired into a benefit-eligible position. I understand that participation in one of the medical options is a prerequisite for participation in the dental option and that all dependents enrolled in health coverage will automatically be enrolled in dental coverage, if dental coverage is elected. I understand I may make changes to my coverage if I experience a status change event (as defined by the Internal Revenue Service; e.g., marriage, divorce, birth, loss of other coverage, etc.) if such change is requested in writing within 90 days of the date of the status change event. If the written request is not submitted to the Benefits Department 90 days, I will forfeit any right to make a change until the next annual open enrollment, if any.

I understand that **eligible dependents** are the person to whom I am legally married and my (or my spouse's) children by birth, placement for legal adoption or foster care, or legal court-appointed guardianship, who are under age 26. I agree to notify the Benefits Department if one of my enrolled dependents is no longer an eligible dependent. I understand that I must provide notification within 60 days in order for the dependent to be eligible for COBRA Continuation Coverage.

Social Security Numbers are Now Required for All Dependents

Beginning January 1, 2009, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires all health plans in the United States to report group and member information to the Centers for Medicare and Medicaid Services (CMS). The new law will help CMS accurately coordinate Medicare and group benefits for people who have both coverages. Since individuals under age 65 who have end stage renal disease or other disabilities are eligible for Medicare, we need to provide information, including social security numbers, for all enrolled members.

AGREEMENT

I hereby make application on behalf of myself and listed eligible family dependents for membership in the University of Utah Employee Health Care Plan as indicated hereon and agree to the terms and conditions in the Master Policy. I understand that if I am eligible and this enrollment form is completed and provided to the University Benefits Department timely, my benefits will begin on my effective date as determined by the enrollment rules of the Plan.

To the minimum extent necessary to implement coverage and to provide coverage benefits, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross/BlueShield of Utah, University Health Care Plus, Blomquist Hale Consulting, UNI BHN, OmedaRX, HealthEquity and ASI Flex to request and use any medical, health, employment, and/or insurance information necessary to complete my enrollment, provide coverage benefits, and administer my coverage benefits. I authorize pretax payroll deduction of contributions as required through the provisions of IRC Section 125 Flexible Benefits. I agree to abide by the Plan's enrollment provisions. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for those companies administering the Plan. To the extent authorized under applicable law, I accept Binding Arbitration as the method of resolving any disputes arising between me or my covered family member and the Plan, or a participating physician, concerning the applicability of benefits payable under the Plan. I understand that the University intends to continue the Plan(s) indefinitely; however, it reserves the right to amend, suspend or discontinue the Plan(s) at any time.

I certify that all information on this form is true and correct and acknowledge that my coverage is subject to cancellation if any completed information is found to be false or incorrect and I will be responsible for reimbursement to the Plan for any claims paid in error. I understand that knowingly providing a statement that contains any false, incomplete or misleading information may result in adverse employment action, up to and including termination of employment.

For detailed plan information, please refer to the Plan's Summary Plan Description. Summary Plan Descriptions are available on the internet at www.hr.utah.edu/ben or in the Benefits Department located at 420 Wakara Way, Ste. #105, Salt Lake City, UT 84108. Phone: (801) 581-7447, Fax: (801) 585-7375, e-mail: benefits@utah.edu

MONTHLY CONTRIBUTION RATES
JULY 1, 2016 THROUGH JUNE 30, 2017

FULL-TIME EMPLOYEES (75% TO 100% FTE) *

All rates are **monthly**

		Medical Only			Medical and Dental		
Network Option	Plan Option	Single	Two-Party	Family	Single	Two-Party	Family
Preferred ValueCare	Advantage	$52.00	$91.00	$137.28	$62.60	$115.30	$175.62
	Comprehensive	$52.00	$91.00	$137.28	$62.60	$115.30	$175.62
	CDHP	$-	$-	$-	$10.60	$24.30	$38.34
BlueCross BlueShield Participating [PAR]	Advantage	$81.66	$142.88	$212.98	$92.26	$167.18	$251.32
	Comprehensive	$81.66	$142.88	$212.98	$92.26	$167.18	$251.32

University Contribution Rates – All Options

Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$509.02	$890.78	$1,343.80	$528.46	$935.46	$1,414.26

PART-TIME EMPLOYEES (50% TO 74% FTE)*

All rates are **monthly**

		Medical Only			Medical and Dental		
Network Option	Plan Option	Single	Two-Party	Family	Single	Two-Party	Family
Preferred ValueCare	Advantage	$306.50	$536.38	$809.18	$326.82	$583.02	$882.74
	Comprehensive	$306.50	$536.38	$809.18	$326.82	$583.02	$882.74
	CDHP	$254.50	$445.38	$671.90	$274.82	$492.02	$745.46
BlueCross BlueShield Participating [PAR]	Advantage	$336.16	$588.26	$884.88	$356.48	$634.90	$958.44
	Comprehensive	$336.16	$588.26	$884.88	$356.48	$634.90	$958.44

University Part-time Contribution Rates – All Options

Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$254.52	$445.40	$671.90	$264.24	$467.74	$707.14

***Complete the requirements to participate in the WellU program to receive a discount of up to $40.00/month from the above rates. If your rate is less than $40.00, you will pay nothing.**

October 1, 2015

IMPORTANT NOTICE to Individuals Enrolled in a University of Utah Health Care Plan Who are Eligible for Medicare or Who Will Become Eligible for Medicare in the Next 12 Months

This notice is required by law and has information about your current prescription drug coverage and your options under Medicare's prescription drug coverage.

The University of Utah has determined that the prescription drug coverage in the University's Employee Health Care Plan and University of Utah Early Retirement Incentive Health Care Plan (the "Plan") is Creditable Coverage.

"Creditable Coverage" means that the amount the Plan expects to pay on average for prescription drugs for individuals covered by the Plan in the 2016 calendar year is the same or more than what standard Medicare D prescription drug coverage would be expected to pay on average.

Because the coverage in the Plan is Creditable, **individuals enrolled in the Plan do not need to purchase separate Medicare D prescription drug coverage as long as you remain enrolled in the Plan.**

If you lose your coverage in the Plan, you may be eligible for a 60-day Special Enrollment Period to sign up for a Medicare D prescription drug plan. If you don't enroll in Medicare D prescription drug coverage during your 60-day Special Enrollment Period or enroll in other creditable coverage (e.g., another employer's group health plan) within 63 days after your current coverage ends, you may only enroll in a Medicare D prescription drug plan during a Medicare Open Enrollment Period (usually October 15th through December 7th) and you could be required to pay a higher monthly premium (including a Medicare penalty) as long as you retain Medicare D prescription drug coverage.

If you have any questions concerning the information provided in this notice, contact the University's Benefits Department at (801) 581-7447. You will receive this notice annually and if the prescription drug coverage through the Plan changes. You may also request a copy at any time by contacting the Benefits Department.

Additional Information from Medicare:
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. The handbook is available on Medicare's website and if you are eligible for Medicare, a copy should be sent to you in the mail each year by Medicare. To get more information about Medicare prescription drug plans and the coverage offered in your area:

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048

For individuals with limited income and resources, extra help paying for a Medicare prescription drug plan may be available. Information regarding this program is available through the Social Security Administration (SSA). Visit SSA online at www.socialsecurity.gov or call the SSA at 1-800-772-1213 (TTY users call 1-800-325-0778).

Keep This Notice

If you enroll in a Medicare D prescription drug plan after May 15, 2006, you may be required to provide a copy of this notice when you join to show that you had Creditable Coverage and are not required to pay a higher premium amount