# HEALTH CARE AND DENTAL COVERAGE ENROLLMENT FORM

| Employee Name | | | | Employee ID # |
|---|---|---|---|---|
| Address | City | State | Zip Code | Home Phone |
| Hire Date ____/____/____ | Email Address: | | | Work Phone |

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

| Network | Plan Design | Dental Coverage | Coverage Level |
|---|---|---|---|
| [ ] University Health Care Plus | [ ] Basic | [ ] Yes | [ ] Single Coverage |
| [ ] ValueCare | [ ] Comprehensive | [ ] Waive | [ ] Two-Party Coverage |
| [ ] BlueCross BlueShield | [ ] Advantage | | [ ] Family Coverage |

| Dependents to be Enrolled | Name (Include last name if different from employee) | Address (If different from employee's address) | Relationship | Birthdate Month/Day/Year |
|---|---|---|---|---|
| Spouse | | | [ ] Husband<br>[ ] Wife | |
| Eligible Dependent Children (See definition of eligible dependents on reverse side of this form) | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] Son | |
| | | | [ ] Daughter<br>[ ] 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 3 months 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 **three months** 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 three months 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 3 months 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 three (3) months of the date of the status change event. If the written request is not submitted to the Benefits Department within 3 months, 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) unmarried children by birth, placement for legal adoption or foster care, or legal court-appointed guardianship, who are under age 26 and dependent on me for more than 50% of their support. 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.

### *PREEXISTING CONDITION WAITING PERIOD*

To the extent allowed under federal law, I understand the health care plan does not cover treatment of preexisting conditions for newly enrolled participants during the first 6 months following enrollment or, for late enrollees, during the first 18 months following enrollment; unless this preexisting condition waiting period is reduced by a period(s) of prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before your Enrollment Date (defined in the Plan):

- You incurred expense, received medical treatment, services or advice, underwent diagnostic procedures, took prescribed drugs or medicine, or consulted a physician or other licensed medical professional; or
- Was discovered or suspected as a result of any medical examination, including a routine medical examination.

The Plan will not impose a waiting period for a preexisting condition for a newborn child, an adopted child, or a child placed with me for adoption if I complete the paperwork to add the child within 3 months of the birth, adoption, or placement, respectively.

### *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 in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross/BlueShield of Utah, University Health Care Plus, and Caremark to request any medical, health, employment, and/or insurance information necessary to complete my enrollment. 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: 581-7447, Fax: 585-7375, e-mail: benefits@hr.utah.edu***

# EMPLOYEE RATES – JULY 1, 2007 THROUGH JUNE 30, 2008

## FULL-TIME (75% TO 100% FTE) EMPLOYEE RATES

*Please Note: All rates are **monthly** and **include dental** coverage*

| Network Option | Plan Option | You Only | You & 1 Dependent | You & 2+ Dependents |
|---|---|---|---|---|
| University Health Care Plus | Basic | □ $22.12 | □ $43.44 | □ $63.74 |
| | Comprehensive | □ $52.78 | □ $95.24 | □ $133.32 |
| | Advantage | □ $69.64 | □ $123.72 | □ $171.56 |
| **Network Option** | **Plan Option** | **You Only** | **You & 1 Dependent** | **You & 2+ Dependents** |
| ValueCare | Basic | □ $30.26 | □ $57.20 | □ $82.22 |
| | Comprehensive | □ $60.92 | □ $109.00 | □ $151.80 |
| | Advantage | □ $77.78 | □ $137.48 | □ $190.04 |
| **Network Option** | **Plan Option** | **You Only** | **You & 1 Dependent** | **You & 2+ Dependents** |
| BlueCross BlueShield | Basic | □ $52.36 | □ $94.54 | □ $132.38 |
| | Comprehensive | □ $83.02 | □ $146.34 | □ $201.96 |
| | Advantage | □ $99.88 | □ $174.82 | □ $240.20 |
| Waive Dental *(Deduct amount shown from above rates)* | | □ -$10.06 | □ -$23.06 | □ -$36.38 |

## PART-TIME (50% TO 74% FTE) EMPLOYEE RATES

*Please Note: All rates are **monthly** and **include dental** coverage*

| Network Option | Plan Option | You Only | You & 1 Dependent | You & 2+ Dependents |
|---|---|---|---|---|
| University Health Care Plus | Basic | □ $224.96 | □ $391.12 | □ $535.08 |
| | Comprehensive | □ $255.62 | □ $442.92 | □ $604.66 |
| | Advantage | □ $272.48 | □ $471.40 | □ $642.90 |
| **Network Option** | **Plan Option** | **You Only** | **You & 1 Dependent** | **You & 2+ Dependents** |
| ValueCare | Basic | □ $233.10 | □ $404.88 | □ $553.56 |
| | Comprehensive | □ $263.76 | □ $456.68 | □ $623.14 |
| | Advantage | □ $280.62 | □ $485.16 | □ $661.38 |
| **Network Option** | **Plan Option** | **You Only** | **You & 1 Dependent** | **You & 2+ Dependents** |
| BlueCross BlueShield | Basic | □ $255.20 | □ $442.22 | □ $603.72 |
| | Comprehensive | □ $285.86 | □ $494.02 | □ $673.30 |
| | Advantage | □ $302.72 | □ $522.50 | □ $711.54 |
| Waive Dental *(Deduct amount shown from above rates)* | | □ - $18.22 | □ - $41.80 | □ - $65.96 |

**IMPORTANT NOTICE TO INDIVIDUALS ELIGIBLE FOR MEDICARE OR WHO WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS**

*Please read this important notice and keep it where you can find it.*

**The University of Utah has determined that the prescription drug coverage offered in the University of Utah Employee Health Care 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 calendar year is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average. Because the University's coverage is Creditable, **University of Utah Employee Health Care Plan members do not need to purchase separate Medicare prescription drug plan coverage as long as you remain enrolled in the University's active employee plan**.

If you drop or lose your coverage in the University of Utah Employee Health Care Plan, you may be eligible for a 60-day Special Enrollment Period to sign up for a Medicare prescription drug plan. If you don't enroll in Medicare 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 prescription drug plan during a Medicare Open Enrollment Period and you could be required pay a higher monthly premium (including a penalty) as long as you retain Medicare prescription drug coverage.

**Additional Information**

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 coverage through the University of Utah Employee Health Care Plan changes. You may also request a copy at any time by contacting the Benefits Department.

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 a copy should be sent to you in the mail each year by Medicare. You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

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

**Help for individuals with limited income and resources**

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