Hospital Plan Plus (HPP)
Benefits Enrollment Information

Remember, you must sign and date all forms and submit them to the Benefits Department within 90 days of your hire date, or transfer date if you are transferring from a non-benefits eligible position to a benefits eligible position.

Health Care and Dental Coverage Enrollment Form:

You have the option to enroll yourself and your eligible dependents in a University sponsored medical and dental plan. For employee premiums please refer to the rate chart found on the back of this form. Your premiums are automatically deducted on a pre-tax basis. Be sure to list each eligible dependent to be covered.

Life Insurance Enrollment Form:

Basic Life Insurance coverage (Part I) is provided for you by the University at no charge. You have the option to obtain additional coverage for yourself and to obtain coverage for your eligible dependents. Premiums for additional coverage are outlined in the respective plan booklets. Be sure to designate a beneficiary in the event of your death. A contingent beneficiary is suggested, but not required. You are automatically designated as the primary beneficiary of any coverage on your dependents.

Additional Benefits Enrollment Form:

Accidental Death and Dismemberment

You have the option to cover yourself and your eligible dependents under the University sponsored Accidental Death and Dismemberment Insurance. You pay the whole premium; see the plan booklet for coverage and premiums. Be sure to indicate a primary beneficiary. A contingent beneficiary is suggested, but not required.

Long Term Disability

You have the option to enroll in the University sponsored Long Term Disability Plan. This policy provides you with a monthly income up to 60% of your covered monthly salary to a maximum determined by your plan. The University contributes toward the cost of this plan.

Long Term Care

You have the option to enroll in the University sponsored Long Term Care Plan. This plan provides coverage for extended nursing home or home health care benefits. You pay the whole premium. If you choose to enroll in this plan, you must also complete an individual application.

Flexible Spending Accounts:

You have the option to participate on a Plan Year basis in the Section 125/Flexible Spending Account. Amounts are deducted each paycheck and are based on the total dollar amount you determine will meet your needs. If you choose to participate in this plan, you must also complete the Section 125/Flexible Spending Account Enrollment Form.

Retirement Enrollment Form:

A TIAA-CREF Enrollment Form will be sent to you following a one-year waiting period. All contributions to your retirement account are made by the University.

Supplemental Retirement Accounts

You may participate in the University's 403(b) and/or 457(b) supplemental retirement plans. To begin making contributions pick up the appropriate forms and investment company information in the Benefits Department or the Employee Service Center at the Hospital.

Status Changes:

If you experience a qualified status change event as defined by the Internal Revenue Code (marriage, birth, adoption, divorce, or death), you have three months from the date of the event to make changes in your benefit plan elections, consistent with the event. If you do not make changes during this three-month period, you will have to wait for the next open enrollment period to make changes.

Change of Beneficiary:

You may change your beneficiaries at any time on your insurance plan(s) by completing a Beneficiary Change Form, which is available on the Benefits website at www.hr.utah.edu or in the Benefits Department. You must contact your retirement plan directly to change beneficiaries. Check with the Benefits Department to find out which companies require a separate Beneficiary Change form.

Section 6109 of the Internal Revenue Code requires you to give your correct social security number to persons who must file information returns with the IRS to report certain information. The University confidentially maintains your social security number for identification purposes and routine uses such as facilitating document matching and administering benefits. The University will provide this information to the IRS, to any third party that provides this information to the IRS on behalf of the University, and may provide this information to agencies to carry out federal or state law.

Remember! Keep a copy of your enrollment forms for your records.

If you have any questions, please contact the Benefits Department at 581-7447.

Hospital Plan Plus Payroll Deduction Worksheet

(for your information only)

Group Life Insurance

Part I		Benefits base (annual salary) to max of $25,000	No cost to employee	N/A
Part II		Benefits base (annual salary) to max of $25,000	Benefits Base x $.25	$
Part III		Dependent coverage of $2,000 per dependent	$.76 total per month, no matter how many covered dependents	$
Supplemental Term Life:	Employee	Max coverage of $350,000 (up to $750,000 may be available for those who qualify)	Rates found in the pamphlet describing this benefit	$
	Spouse	Max coverage of $250,000		$
	Dependent Child	$5,000 or $10,000	$.60 or $1.20 total per month	$
Group Universal Life		Max coverage of $150,000	Rates can be obtained by calling Hawkins & Associates at 272-5353	$
Total Group Life Insurance Monthly Deduction				**$**

Accidental Death and Dismemberment

Single Coverage	$.19 per $10,000 of coverage	$
Family Coverage	$.36 per $10,000 of coverage	$
Total Accidental Death & Dismemberment Monthly Deduction		**$**

Long Term Disability

HPP Participants	$.01066 x's covered monthly salary, minus $10.00 (full-time) / $5.00 (part-time) contribution made by University.	$
Total Long Term Disability Monthly Deduction		**$**

Long Term Care

Long Term Care employee rates are listed on page 16 of the booklet	$
Total Long Term Care Monthly Deduction	**$**

Medical/Dental Plan

		Indemnity		ValueCare Basic		ValueCare Preferred		UUHP	
		Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	Medical Only	$57.72	**$186.52**	$5.00	**$146.64**	$63.68	**$192.48**	$35.16	**$181.80**
	Medical & Dental	$67.38	**$203.88**	$14.66	**$164.00**	$73.34	**$209.84**	$44.82	**$199.16**
Two Party	Medical Only	$136.54	**$332.62**	$25.00	**$244.40**	$128.64	**$324.72**	$73.44	**$317.84**
	Medical & Dental	$158.68	**$372.46**	$47.14	**$284.24**	$150.78	**$364.56**	$95.58	**$357.68**
Family	Medical Only	$241.74	**$454.94**	$40.00	**$327.66**	$229.66	**$442.86**	$106.86	**$434.52**
	Medical & Dental	$276.66	**$517.76**	$74.92	**$390.48**	$264.58	**$505.68**	$141.78	**$497.34**
Total Medical/Dental Plan Deduction								**$**	

Total Monthly Deduction $__________

(1/2 taken from each paycheck received the 7th & 22nd of each month)

HPP HEALTH CARE AND DENTAL COVERAGE ENROLLMENT FORM

Last Name		First Name		Middle Initial

SS#	Empl ID#	Birth Date ____/____/____	Male [ ] Female [ ] Single [ ] Married [ ]

Address	City	State	Zip Code	Work Phone	Home Phone

Hire Date ____/____/____	e-mail address:

Health Care Coverage
[ ] ValueCare Preferred [ ] Indemnity
[ ] ValueCare Basic [ ] UUHP
[ ] Waive*

*See the back of this form for details on receiving the $25 Health Waiver Benefit

Dental Coverage
[ ] Yes [ ] Waive

I am applying for
[ ] Single Coverage
[ ] Two-Party Coverage
[ ] Family Coverage

Dependent Type	Name	Social Security Number	Indicate Relationship	Birthdate Month/Day/Year
Spouse			[ ] Husband [ ] Wife	
Dependent Children (Includes: Adopted Children, Step Children, and Legal Guardianship Children. Please include surname if different from employee.)			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	
			[ ] Daughter [ ] Son	

I have read the benefits information provided and I agree to the conditions contained on the back of this form. I understand I must enroll in health care coverage within 90 days of my date of hire or transfer into a benefits eligible position from a non-eligible position. 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 I do not meet these deadlines, I forfeit any right to health care coverage until Open Enrollment. 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 to bring my deduction balances current. I understand if my FTE drops between 50-74%, I will be charged the part-time premium automatically, and must notify the Benefits Department within three months if I wish to cancel or change coverage. I understand if my FTE drops below 50%, I will not be eligible and my coverage will be terminated. 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 containing any misrepresentation or any false, incomplete, or misleading information I may be subject to discipline up to and including termination, and may be guilty of a criminal act punishable under law and subject to civil penalties.

Employee Signature: ______________________________ Date: ______________________

WAIVER OF HEALTH CARE COVERAGE

I understand that by waiving health care coverage now, I will not be able to enroll in the plan until the next open enrollment period, or during a special enrollment period as described below. I understand that in order to receive the Health Waiver Benefit of $25 per month I must provide proof of other coverage (refer to the back of this form for more information). I wish to waive health care coverage for:

[ ] myself [ ] my spouse [ ] all dependent children [ ] the following dependent children: ______________________

I am waiving University of Utah health care coverage due to other coverage: [ ] Yes [ ] No

If you are declining enrollment for yourself or your dependent(s) (including your spouse) due to other health care coverage, you may in the future be able to enroll the person(s) for whom enrollment is declined, provided you request enrollment within three months after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within three months after the event. If you do not enroll within this three month window, you will not be eligible to enroll until the next open enrollment period.

Benefits Dept. Use Only >	Effective Date: ___/___/___	Benefit Program:	Retirement Plan [ ] T-C [ ] UT [ ] PS	Comments:

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, etc.) if such change is made 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.

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. I understand that a preexisting condition is a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received. Treatment includes taking a prescription medication. Pregnancy is not considered a preexisting condition. 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 Blue Cross/Blue Shield of Utah, UUHP, 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 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.

I understand that disclosure of my Social Security Number on this form is ***Necessary***. Its use is to facilitate the administrative processing of my health and dental coverage.

PRIVACY ACT NOTICE: Section 6109 of the Internal Revenue Code requires you to give your correct social security number to persons who must file certain information returns with the Internal Revenue Service ("IRS"). The University must report to the IRS any payments paid through benefits programs using the payee's correct social security number. If a benefit payment to be paid to you or your beneficiary must be reported to the IRS, failure to provide a social security number for the payee at this time may result in a delay in processing your payment, as the payee will be required to provide his or her correct social security number prior to disbursement. Failure to provide the appropriate social security number may result in unnecessary delay, such as the administrator's refusal to make payments without verifying your eligibility. Providing a social security number at this time is voluntary, but necessary for prompt administration of your benefits. Routine uses may include verifying your identity, and tracking your medical history, drug allergies, and pre-existing conditions. The University will use your social security number, with your consent, for these purposes. The University will also provide this information to any benefit provider who must file an information return, and may provide this information to other agencies to carry out federal or state law.

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.

For detailed plan information, please refer to the Plan's Summary Plan Description.
Summary Plan Descriptions are available through 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

HPP LIFE INSURANCE ENROLLMENT FORM

Name		Empl ID# SS#

If you enroll during your Initial Enrollment Period (first 3 months following your date of hire into a benefit-eligible position with the University), you may enroll in Parts II and III, and Supplemental Term and Group Universal Life coverage on your own life (a combined amount of Supplemental Term and Group Universal Life up to $350,000) without providing evidence of insurability.

If you would like additional coverage or are enrolling after your Initial Enrollment Period, you are required to apply for coverage and provide evidence of insurability (enrollment is not guaranteed).

Please indicate beneficiary designations on the back of this form.

Part I Automatic

Life insurance in the amount of your annual salary up to a maximum of $25,000.
No cost to employee

Part II

Life Insurance in an amount equal to Part I coverage (your annual salary up to a maximum of $25,000).
Employee cost = $.25 per 1,000 per month

Enroll [ ] Yes [ ] No

Part III

Life Insurance in the amount of $2,000 each on your spouse and each eligible dependent child.
You must enroll in Part II to enroll in Part III.
Employee Cost = $.76 per month

Enroll [ ] Yes [ ] No

Employee Voluntary Life Insurance

Supplemental Term

Have you used tobacco in any form in the past 12 months?
[ ] Yes [ ] No

Life insurance for minimum of $20,000 up to maximum of $500,000 (or five times your annual salary up to $750,000) in $5,000 increments. Refer to summary booklet for details and rates.

Life insurance amount desired $______________________

Enroll [ ] Yes [ ] No

Group Universal*

Minimum $10,000 up to maximum of $150,000 in $1,000 increments.
* To receive a rate quote and additional enrollment forms you MUST call Hawkins & Associates at 272-5353. *(Enrollment will not be processed until all additional enrollment forms are submitted.)*

Life insurance amount desired $______________________

Daytime Phone: ________________ (required)

Enroll [ ] Yes [ ] No

Dependent Voluntary Term Life Insurance

You must be enrolled in Supplemental Term Insurance to participate in this option.

Spouse Supplemental Term

Has your spouse used tobacco in any form in the past 12 months? [ ] Yes [ ] No

Minimum $20,000 up to maximum of $250,000 in $5,000 increments (cannot exceed amount of your Supplemental Term coverage amount unless you have been denied coverage). Refer to summary booklet for details and rates.

Life insurance amount desired $____________________

Enroll [ ] Yes [ ] No

Dependent Supplemental Term

[ ] $5,000 ($.60 per month)

[ ] $10,000 ($1.20 per month)

Enroll [ ] Yes [ ] No

I have read and understand the insurance coverage information on this form and in the Description of Life Insurance Benefits Booklet. I agree to the terms of the coverage elected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize any payroll deductions of required premiums.

Employee Signature: ____ **Date:** ____________________________

BENEFICIARY DESIGNATIONS

Please designate at least one Primary Beneficiary and one Contingent Beneficiary for each coverage you elect (the percent allocation must add up to 100 for each group)

(You are automatically the Primary Beneficiary if you enroll in Part III, Spouse Supplemental Term and/or Dependent Supplemental Term Life Insurance)

Parts I and II	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Part III	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse/Parent	100
Contingent Beneficiary(ies)			

Employee Supplemental	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Group Universal	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Spouse Supplemental	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse	100
Contingent Beneficiary(ies)			

Dependent Supplemental	Name	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Parent	100
Contingent Beneficiary(ies)			

You may change your beneficiary designation(s) at any time. Contact the Benefits Department or visit the Benefits Department's web site at www.hr.utah.edu/ben for forms and information.

HPP ADDITIONAL BENEFITS ENROLLMENT FORM

Name		Empl ID#	SS#

Accidental Death and Dismemberment Insurance

(Combined Insurance Company of America, Policy Number 42713VA)

This optional insurance allows employees to insure themselves and eligible family members against covered accidents in an amount up to $500,000. Dependents covered under this plan are covered only for a specified percentage of the employee's elected coverage. (See Plan Booklet for specific details.) Evidence of insurability is never required to enroll in this coverage.

Select one of the following options:

[ ] Employee Only Coverage ($.19 per $10,000 of coverage)
[ ] Employee and Family Coverage ($.36 per $10,000 of coverage)
[ ] Waive

Coverage amount desired: $_________________

Designate at least one Primary and one Contingent Beneficiary (if more than one, state percent of benefit to go to each person):

Primary Beneficiary: ____ Relationship to Employee: _____________

Contingent Beneficiary: ____ Relationship to Employee: _____________

(Employee is beneficiary for coverage on family members)

Long Term Disability Insurance *(Standard Insurance Company)*

Long Term Disability Insurance – Campus and UUHC

This optional insurance provides employees who have an eligible disability with up to 60% income replacement (less certain income from other sources and subject to plan maximums) following the applicable elimination period. I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability. See instruction sheet for current University and Employee contribution rates. I understand that my position and rate of pay determines the policy I am enrolled in and my premium. I agree that if my position and/or rate of pay changes, my policy and premium will change accordingly.

[ ] Elect [ ] Waive

Long Term Disability Insurance - School of Medicine

Eligible SOM employees must obtain enrollment forms for this plan through their department.

This optional insurance provides employees who have an eligible disability with up to 60% income replacement (less certain income from other sources and subject to plan maximums) following the applicable elimination period. I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability. See instruction sheet for current University and Employee contribution rates. I understand that my position and rate of pay determines the policy I am enrolled in and my premium. I agree that if my position and/or rate of pay changes, my policy and premium will change accordingly.

[ ] **I understand I must contact my department administrator for definition of benefits, enrollment form, and rates.**

Long Term Care Insurance

(CNA Insurance Companies Policy Number 31A9487)

If you enroll in the Long Term Care Insurance, you must also complete and return a separate application - Rates can be found in the CNA Long Term Care information packet. Parents and grandparents must complete a different application and are billed by the insurance carrier.

This optional insurance provides coverage for nursing home, adult day care and home-based care. Coverage is available for an employee, his/her spouse, and the parents and grandparents of the employee and spouse. I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability.

I choose to enroll in the Long Term Care Insurance and am enclosing my CNA application form:

Myself	[ ] Yes	[ ] No
My Spouse	[ ] Yes	[ ] No

I have read and understand the information provided. I agree to the terms of the plans selected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize payroll deductions of premiums as required.

Employee Signature: ____ Date: ______________________

HPP FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Name	SS#	Empl ID#

Address	City	State	Zip	Daytime Phone ( )

Flexible Benefit Plan

(Administered by Wells Fargo Health Benefit Services)

A flexible spending account ("FSA") allows employees to be reimbursed with pre-tax dollars for qualifying out-of-pocket health care and/or day care expenses. New employees and employees who are transferring from a non-benefit eligible position to a benefit-eligible position may make an election within 3 months of their hire/transfer date or must wait until the next annual open enrollment period. Only qualified expenses incurred after the beginning of the Plan Year or the employee's effective date, whichever is later, through the end of the Plan Year or the date the employee terminates participation in the Plan, whichever is earlier, are eligible for reimbursement. Employees may only change or cancel elections if they experience a qualified status change event consistent with the requested change. **Changes to an FSA election must be completed within three months of the date of the status change event**.

HEALTH FLEXIBLE SPENDING ACCOUNT

I elect an annual deferral of $_____________ to the Health FSA on a pre-tax basis (minimum of $5 per paycheck – maximum of $6,000 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

I elect an annual deferral of $_____________ to the Dependent Care FSA on a pre-tax basis (minimum of $5 per paycheck – maximum of $5,000 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year.

- The Internal Revenue Service limits the amount employees may defer to a Dependent Care FSA to $5,000 per calendar year per family.
- Expenses for the care of a qualifying individual are eligible for reimbursement under a Dependent Care Flexible Spending Account if they are necessary in order to allow you to work and are for the care of: (a) Your child or children age 12 or younger; (b) Your spouse who is physically or mentally incapable of caring for himself or herself and resides with you for more than one-half of the calendar year; or (c) Your other dependent (e.g., your parent or child age 13 or older), who is physically or mentally incapable of caring for himself or herself and resides with you for more than one-half of the calendar year (to be considered your "dependent" the individual must be someone you could claim as an exemption on your taxes, including the fact that the individual must have gross income less than the IRS tax exemption amount - $3,200 for 2005).

To estimate your per paycheck amount, complete the following worksheet. For information or assistance, contact the Benefits Department at 581-7447.

	Amount
Plan Year Election	$____,_______.___
Number of Pay Periods Remaining in Plan Year	÷ ________
Per Paycheck Amount	$____,_______.___

IMPORTANT!
The per paycheck amount is only an *estimate*. The actual amount will depend on the pay period in which your enrollment is entered in to the payroll system.

I understand and authorize the following:

- I elect the benefits indicated above and authorize the appropriate payroll deferrals.
- I cannot change my election during the Plan Year unless I experience a qualified status change event and request the change within three months.
- I forfeit any amounts left in my Health FSA and/or Dependent Care FSA after all eligible expenses are submitted for reimbursement. **(Eligible expenses must be submitted no later than September 30 following the end of the Plan Year.)**
- If I terminate my employment or transfer to a position not eligible to participate in this benefit, only eligible expenses incurred prior to that date will be reimbursed. I may, however, elect to continue participation through COBRA.
- I must reenroll during open enrollment each year to participate in this benefit during the next Plan Year.
- I am responsible to keep and submit all receipts to Wells Fargo Flex Benefit Services for reimbursement of unreimbursed health and/or dependent care expenses. If I use my Benny® MasterCard™ for Health FSA purchases, I will not need to submit my receipt to Wells Fargo Flex Benefit Services unless asked to verify that the expense was an eligible expense.
- I agree to use my Benny® MasterCard™ for eligible Health FSA expenses that have not already been reimbursed and will not seek reimbursement of those expenses under another health plan.

I have read and understand the Flex Benefit Plan information. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize the payroll deductions of amounts elected.

Employee Signature: ____ **Date:** ______________________

University of Utah
Employee Health Care Plan

HPP BENEFIT PROGRAM

HOSPITAL PLAN PLUS

Summary Comparison of Medical & Dental Options

Effective July 1, 2005	Indemnity Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 91070**	ValueCare Basic Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 20141**	ValueCare Preferred Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 20029**	University of Utah Health Plan "UUHP" Option www.uuhsc.utah.edu/uhealthplan **587-6480 or 1-888-271-5870** **Group # 13320**
Eligibility	**Effective Date**: If employees enroll during their Initial Enrollment Period, coverage begins on the first day of the month following the date of hire/eligibility (if this date is the first of the month, coverage begins that day). If employees enroll during open enrollment, coverage begins on the first day of the plan year following open enrollment. **Pre-existing Conditions**: Covered after six-month waiting period (18 months for late enrollees), unless proof of previous creditable coverage meets HIPAA requirements. **Termination Date**: Coverage will end the last day of the pay period in which employment is terminated. For a dependent who loses eligibility, coverage ends at 12:01 am on the date of the event.			
Definition of Dependent	**Eligible Dependents** are the person to whom you are legally married and your (or your 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 you for more than 50% of their support. Coverage may be continued at age 26 under certain circumstances. Review the Health Care Plan Summary Descriptions or contact the Benefits Department for additional information.			
Providers and Eligible Charges	All the plans provide coverage for eligible charges even when you do not use participating or in-network providers or facilities. However, the plan will limit eligible charges to the amount that would have been paid to a participating provider and you may be required to pay the difference in addition to your share of the covered amount. In this document coverage for network providers in the ValueCare Basic and ValueCare Preferred plans is indicated by "VC"; Coverage for network providers in the University of Utah Health Plan is indicated by "UUHP"; and "UH" indicates the University of Utah Hospital when different from other UUHP network providers.			
Number of Network Providers	42 Hospitals 3954 Physicians 37 Urgent Care Centers	35 VC Hospitals 3801 VC Physicians 30 VC Urgent Care Centers	35 VC Hospitals 3801 VC Physicians 30 VC Urgent Care Centers	14 UUHP Hospitals 1757 UUHP Physicians 14 UUHP Urgent Care Centers **MultiPlan (National Network)**
Lifetime Maximum Benefit	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Plan Year Deductible	$200 per individual [Three (3) family member maximum]	$250 per individual [Three (3) family member maximum]	In-network - None Out-of-network - $100 per individual [Three (3) family member maximum]	In-network - None Out-of-network - $100 per individual [Three (3) family member maximum]
Plan Year Medical Maximum Coinsurance (after deductible)	$1,000 per member [Three (3) family member maximum]	In-network - $1,500 per member [Three (3) family member maximum] Out-of-network - $3,000 per member [Two (2) family member maximum]	In-network - $1,000 per member [Three (3) family member maximum] Out-of-network - $3,000 per member [Two (2) family member maximum]	In-network - $1,000 per member [Three (3) family member maximum] Out-of-network - $3,000 per member [Two (2) family member maximum]
Outpatient Hospital, Professional Services, Lab/X-Ray	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 90% Non-VC: 70% after deductible	UUHP: 90% Non-UUHP: 60% after deductible
Inpatient Hospital Charges	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 90% Non-VC: 70% after deductible	UH: 100% UUHP: 90% Non-UUHP: 60% after deductible
Office Visits, Urgent Care Facilities	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 100% after $15 copay Non-VC: 70% after deductible	UUHP: 100% after $15 copay Non-UUHP: 60% after deductible
Hospital Emergency Room for Medical Emergency	80% after deductible	VC/Non-VC: 70% after deductible	VC/Non-VC: 100% after $75 copay	UUHP/Non-UUHP: 100% after $75 copay
Maternity - Physician	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 90% Non-VC: 70% after deductible	UUHP: 90% Non-UUHP: 60% after deductible

Effective July 1, 2005	Indemnity Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 91070**	ValueCare Basic Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 20141**	ValueCare Preferred Option www.ut.regence.com **333-2110 or 1-800-624-6519** Claims Fax # 333-6523 **Group # 20029**	University of Utah Health Plan "UUHP" Option www.uuhsc.utah.edu/uhealthplan **587-6480 or 1-888-271-5870** **Group # 13320**
Well Baby Care and Immunizations (through age 5)	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 100% after $15 copay Non-VC: 70% after deductible	UUHP: 100% after $15 copay Non-UUHP: 60% after deductible
Diabetic Supplies covered at Pharmacy: syringes, lancets, alcohol swabs, test strips	You pay 20% at participating pharmacy when you use your Health Plan ID card	You pay 30% at participating pharmacy when you use your Health Plan ID card	You pay 20% at participating pharmacy when you use your Health Plan ID card	You pay 20% at participating pharmacy when you use your Health Plan ID card
Physical Exam (one professional exam and one OB-GYN exam limited to $500 per member per plan year)	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 100% after $15 copay Non-VC: 70% after deductible	UUHP: 100% after $15 copay Non-UUHP: 60% after deductible
Hearing and Vision Exams (one each per member per plan year)	80% after deductible	VC: 70% after deductible Non-VC: 50% after deductible	VC: 100% after $15 copay Non-VC: 70% after deductible	UUHP: 100% after $15 copay Non-UUHP: 60% after deductible
Eyeglasses & Contact Lenses	• All University of Utah employees and their benefit eligible family members receive the following discounts at the Moran Eye Center's nine community optical locations: Refractive Surgery • LASIK offered at cost through a variety of studies starting at $700.00 per eye • Employee and eligible family may receive $550.00 per eye discount off standard fee • Free Screening exams for LASIK at Moran Eye Center, Old Mill location. To schedule a free evaluation call 585-EYES Eyeglasses • 30% discount on frames • 20% discount on lenses • 1 year breakage warranty at no additional cost Contact Lenses • 10% discount off retail price on contact lens products • Up to 50% off (retail pricing) on Bausch and Lomb brand of contact lens solution • Contact lens trials available • Knighton Optical Shops may also offer a discount off retail price for members of the Indemnity, ValueCare Preferred or ValueCare Basic plans if you present your health plan (BlueCross) ID card. (The Knighton Optical discount is not available for UUHP members)			

Prescription Drug Benefit Summary

Prescription Drugs: Coordination of benefits only between two University health plans when both husband and wife work at the University	**UUHC Pharmacies:** You pay 20% (minimum $3) for covered generic and brand name (preferred and non-preferred) prescription drugs when you use your Health Plan ID Card. **Non-UUHC Participating Pharmacies:** You pay 25% (minimum $3) for covered generic and preferred brand name prescription drugs and 35% (minimum $3) for non-preferred brand name prescription drugs when you use your Health Plan ID Card. The plan pays 100% of eligible charges after the plan has paid $4,000 for one individual ($12,000 for family). **www.caremark.com** If a generic drug is available, but the member **chooses** to purchase the brand name drug, the member will pay the coinsurance for the generic drug, plus the difference in cost between the brand name drug and the generic.

Behavioral Health Benefit Summary

Behavioral Health Services with or without EAP referral cannot exceed total of: 30 days for inpatient per Plan Year; 20 visits for outpatient per Plan Year; or 2 chemical dependency courses of treatment per lifetime (not to exceed $10,000 per course of treatment)		Short Term Counseling	Behavioral Health Services	Chemical Dependency Treatment
	When you use the EAP	No cost to you	INPATIENT Hospital/Professional services: 80% up to 30 days per plan year OUTPATIENT office visits: $20 copay up to 20 visits per plan year	INPATIENT services: 80% per course of treatment OUTPATIENT services: 80% per course of treatment Maximum Benefit: $10,000 per course of treatment
	When you don't use the EAP	N/A	INPATIENT Hospital/Professional services: 50% of allowable charges after $200 deductible per confinement, up to 30 days per plan year OUTPATIENT office visits: 50% of allowable charges up to 20 visits per plan year	INPATIENT services: 50% after $300 deductible, per course of treatment OUTPATIENT services: 50% per course of treatment Maximum Benefit: $3,500 per course of treatment

Dental Option Summary

Dental Plan Option administered by Regence BlueCross BlueShield *(Indemnity, ValueCare Basic, ValueCare Preferred and UUHP participants)*	
Providers	Patient may choose any dentist. All benefits based on RBCBS schedule of eligible dental expenses.
Deductible	None
Basic Coverage (Exams, X-rays, cleanings, fillings, sealings, periodontics, endodontics.)	80% of RBCBS Schedule of Benefits
Prosthodontics (Bridges, Crowns, Dentures)	50% of RBCBS Schedule of Benefits
Orthodontics	50% of RBCBS Schedule of Benefits
Maximum Benefit: Basic Coverage and Prosthodontics Orthodontics	 $2,000 per plan year - per member $2,000 lifetime per member

This Health Care Plan Summary contains only a general description of some of the features of the University's Employee Health Care Plan options. The exact details of the Plan are included in the governing legal plan document.

Monthly Health Premiums

Half of the monthly premium is deducted on a pre-tax basis from the employee's paycheck on or around the 7th and 22nd of the month.

	Indemnity		**ValueCare Basic**		**ValueCare Preferred**		**University of Utah Health Plan**	
	Full-Time	**Part-Time**	Full-Time	**Part-Time**	Full-Time	**Part-Time**	Full-Time	**Part-Time**
Employee Medical	$66.40	**$214.56**	$5.00	**$168.68**	$73.26	**$221.42**	$40.44	**$209.12**
Employee Medical & Dental	Add $10.06 Total $76.46	**Add $18.22 Total $232.78**	Add $10.06 Total $15.06	**Add $18.22 Total $186.90**	Add $10.06 Total $83.32	**Add $18.22 Total $239.64**	Add $10.06 Total $50.50	**Add $18.22 Total $227.34**
Two-Party Medical	$157.06	**$382.60**	$25.00	**$281.12**	$147.96	**$373.50**	$84.48	**$365.60**
Two-Party Medical & Dental	Add $23.06 Total $180.12	**Add $41.82 Total $424.42**	Add $23.06 Total $48.06	**Add $41.82 Total $322.94**	Add $23.06 Total $171.02	**Add $41.82 Total $415.32**	Add $23.06 Total $107.54	**Add $41.82 Total $407.42**
Family Medical	$278.06	**$523.30**	$40.00	**$376.90**	$264.16	**$509.40**	$122.92	**$499.82**
Family Medical & Dental	Add $36.38 Total $314.44	**Add $65.94 Total $589.24**	Add $36.38 Total $76.38	**Add $65.94 Total $442.84**	Add $36.38 Total $300.54	**Add $65.94 Total $575.34**	Add $36.38 Total $159.30	**Add $65.94 Total $565.76**