University of Utah
Benefits Enrollment Information

THE UNIVERSITY'S PLAN YEAR FOR ALL BENEFITS RUNS FROM JULY 1 THROUGH THE FOLLOWING JUNE 30 – OPEN ENROLLMENT IS IN APRIL EACH YEAR

COMPLETE THE FOLLOWING FORMS AND SUBMIT THEM WITHIN 90 DAYS OF YOUR DATE OF HIRE:

1. **Health Care and Dental Coverage Enrollment Form:** You have the option to enroll yourself, legal spouse, qualified domestic partner, &/or your eligible dependents in the University Employee Health Care Plan. Be sure to list each eligible dependent to be covered. For employee contribution rates, please refer to the health plan rate chart. Your contributions are automatically deducted from your pay on a pre-tax basis. The University is committed to supporting employee wellness efforts through the WellU Wellness program. Putting a priority on wellness will help build a healthier University workforce. University employees who complete the optional WellU requirements receive a discount on their cost of health coverage of up to $40 per month.

2. **Flexible Spending Account Enrollment Form:** You have the option to participate on a Plan Year basis in the University's Flexible Spending Account Plan (Section 125). If you choose to participate in a Health Care FSA for reimbursement of eligible medical expenses, or in a Dependent Care FSA for reimbursement of daycare expenses for your eligible dependents, you must complete the enclosed form. You make an annual election and the amount you elect will be divided equally among the paychecks you receive during the Plan Year and deducted pre-tax. Amounts are deducted each paycheck and are based on the total dollar amount you determine will meet your needs. You must reenroll each year during Open Enrollment if you wish to participate in future plan years. FSA elections you make are irrevocable during the plan year; however, IRS regulations will allow you to change your election amount if you experience a status change.

3. **Long Term & Short Term Disability Form:** Disability insurance provides an income replacement benefit in the event you are unable to work because of an eligible disability. This policy provides you with a monthly benefit up to 60% of your covered monthly salary to a maximum determined by your plan.

4. **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 booklet. 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.

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

6. **Retirement Enrollment Forms:** The University provides retirement benefits for most employees in benefit-eligible positions. However, saving additional funds for retirement is a very important and personal decision. Consider contributing either pre-tax or after-tax funds to one of the University's supplemental retirement plans. 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 visit https://www.hr.utah.edu/benefits/retirement.php.

7. **Home & Auto:** The University has partnered with three companies to provide this coverage: Liberty Mutual Insurance, MetLife Home and Auto, and Safeco Insurance. If you enroll in coverage through the University, premiums will be deducted directly from your paychecks. To obtain quotes or receive additional information on available coverage, contact the respective company.

8. **Group Legal Plan:** You may enroll in the Group Legal Plan through Hyatt Legal for the remainder of the Plan Year. See the enrollment form or visit www.legalplans.com (enter password 4940030) for coverage information. Coverage continues from year to year unless you elect to discontinue coverage during open enrollment. If you do not enroll during your Initial Enrollment Period, you may enroll during a future Open Enrollment period.

9. **Long Term Care:** You have the option to enroll in the Long Term Care Plan. This plan provides coverage for extended nursing home or home health care benefits. You pay the whole premium for this plan. In order to enroll in this plan or receive additional information, visit https://www.hr.utah.edu/benefits/longtermcare.php.

ADDITIONAL BENEFITS INFORMATION:

Status Changes: If you experience a qualified status change event as defined by the Internal Revenue Code (marriage, birth, adoption, divorce, death, loss of other group coverage), you have 90 days from the date of the event to make changes in your health plan and flexible spending account elections, consistent with the event. If you do not make changes during this 90-day period, you will have to wait for the next open enrollment period to make changes.

Change of Beneficiaries: You may change your beneficiaries on your insurance plan(s) at any time 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.

If you have any questions, please contact the Benefits Department at (801) 581-7447. Find additional Benefits information by visiting: www.hr.utah.edu/benefits. Completed enrollment forms may be faxed to the Benefits Department at (801) 585-7375. Please keep a copy of your enrollment forms for your records.

HEALTH CARE AND DENTAL COVERAGE ENROLLMENT FORM

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

SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2016

Provider Network Options		
Preferred ValueCare	Find a Provider www.regence.com (888) 370-6159	All University of Utah Health Care facilities and providers, in addition to over 8,600 providers throughout the State of Utah; access to 40 hospitals and all urgent care centers in Utah; and nationwide coverage through BlueCard Network.
Participating (PAR)		All University of Utah Health Care facilities and providers, in addition to over 8,700 providers throughout the State of Utah (including Intermountain Healthcare facilities and providers); access to 49 hospitals and all urgent care centers in Utah; and nationwide coverage through BlueCard Network.

Health Plan Design Options	Advantage	Comprehensive	Consumer Directed Health Plan (CDHP)
Plan Year Deductible	In-Network: $0 Out-of-Network: $350 per member $700 per family	University Provider: $0 Other Provider: $350 per member $700 per family	$1,500 per member $3,000 per family
Plan Year Medical Maximum Coinsurance	$2,000 per member $5,000 per family	$2,000 per member $5,000 per family	$5,000[1] per member $10,000[1] per family
Employee Voluntary Health Savings Account Contribution Maximum	N/A	N/A	Single: $3,350 Two-Party/Family: $6,650

THE AMOUNT YOU PAY FOR COVERED SERVICES:	Advantage			Comprehensive			CDHP
	University of Utah Health Care Providers	Other Network Providers	Out-of-Network Providers	University of Utah Health Care Providers	Other Network Providers	Out-of-Network Providers	Preferred ValueCare Network Providers and Out-of-Network Providers
Inpatient Hospital	0%	20%	35%	5%	25%	35%	30%
Emergency Room	$150 copay			25%			30%
Ambulance Services	20%			25%			30%
Lab/X-Ray, Outpatient Hospital, Professional Services	0%	20%	35%	5%	25%	35%	30%
Office Visit / Urgent Care Center *Not required for preventive or well woman visit*	$5 copay	$30 copay	35%	5%	25%	35%	30%
Preventive Services and Screening Procedures	0%	0%	35%	0%	0%	35%	Network: 0% Out-of-Network: 30%
Rehabilitation Services *Inpatient: limited to 30 days per Plan Year*	0%	20%	35%	5%	25%	35%	30%
Durable Medical Equipment, Orthotic and Prosthetic Devices	0%	20%	35%	5%	25%	35%	30%

[1] Plan Year Medical Maximum Coinsurance includes Deductible, Prescription Drug, and Behavioral Health/Chemical Dependency claims in the CDHP option only.

	Advantage			Comprehensive			CDHP
	University of Utah Health Care Providers	Other Network Providers	Out-of-Network Providers	University of Utah Health Care Providers	Other Network Providers	Out-of-Network Providers	Preferred ValueCare Network Providers and Out-of-Network Providers
Neurodevelopmental Therapy ▪ *Children age 18 and under* ▪ *Limited to $1,500/Plan Year* *Age and dollar limits do not apply to other covered Speech Therapy Services*	0%	20%	35%	5%	25%	35%	30%
Spinal Manipulation *Limited to 20 per Plan Year*	$5 copay	$30 copay	35%	5%	25%	35%	30%
Hearing / Vision Exams *Limited to one each per Plan Year*	$5 copay	$30 copay	35%	5%	25%	35%	30%

	Advantage and Comprehensive	CDHP
Prescription Medication Coverage	**Out-of-Pocket Maximum***: $150 per script per 30-day supply* *$2,000 per Individual / $4,000 per Family total cost per year*	30% *(after deductible has been met; applied to medical out-of-pocket maximum)*
	University Health Care Pharmacies: 20% generic and brand name	
	Other Participating Pharmacies: 25% generic and preferred brand name 35% non-preferred brand name	

		Advantage	Comprehensive	CDHP
Behavioral Health and Chemical Dependency Services	**Out-of-Pocket Maximum**	$2,000 per Individual $4,000 per Family	$2,000 per Individual $4,000 per Family	*Applied to medical out-of-pocket max*
	Employee Assistance Program (EAP)	No cost to health plan members and other family members residing in the employee's household		
	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*	**When you use the EAP**: Inpatient services: 20% up to 30 days per plan year		Behavioral Health Services: 30% *(Day and visit limits do not apply)*
		When you use the EAP: Outpatient services: $25 copay up to 20 visits per plan year		
		When you do not use the EAP: Inpatient services: 50% of allowable charges after $200 deductible per confinement, up to 30 days per plan year		
		When you do not use the EAP: Outpatient services: 50% of allowable charges up to 20 visits per plan year		
	Chemical Dependency Services *With or without EAP referral cannot exceed 2 courses of treatment per lifetime*	**When you use the EAP**: Inpatient services: 20% per course of treatment		Chemical Dependency Services: 30% *(Course of Treatment limits do not apply)*
		When you use the EAP: Outpatient services: 20% per course of treatment		
		When you do not use the EAP: Inpatient services: 50% after $300 deductible per course of treatment		
		When you do not use the EAP: Outpatient services: 50% per course of treatment		

Eyeglasses and Contact Lenses	Discounts on LASIK eye surgery, eyeglasses, contact lenses and supplies at the Moran Eye Center. Payroll deduction is available for qualifying LASIK procedures done by Moran's vision correction surgeons and up to $1,000 on eyewear at ten community optical locations. http://healthcare.utah.edu/moran/patient_care/optometry/employee-services.php

Dental Coverage Option	
Regence Dental Network	Find participating providers at: www.regence.com/find-a-doctor (search for General Dentistry or Pediatric Dentistry) All benefits are paid based on the Regence schedule of eligible dental expenses
Deductible	None
Maximum Benefits	Basic Coverage and Prosthodontics: $2,000 per plan year - per member Orthodontics: $2,000 lifetime per member
THE AMOUNT YOU PAY FOR COVERED SERVICES:	
Basic Coverage *Exams, X-rays, cleanings, fillings, sealings, periodontics, endodontics*	20%
Prosthodontics *Bridges, Crowns, Dentures*	50%
Orthodontics	50%

Eligible Family Members: Spouse or domestic partner and children under age 26 (includes children placed for adoption, legal guardianship, and foster care, and the children of your spouse or domestic partner). Coverage for children continues through the end of the month in which the child turns age 26 and may be continued after that date only if they are a full-time student or disabled. *See the Summary Plan Description for eligibility rules.*

Out-of-Network coinsurance amounts shown are paid based on Eligible Medical Expenses (the amount a network provider has agreed to accept as payment in full for the services). **Members may be billed by an out-of-network provider for amounts that exceed the amount a network provider has agreed to accept as payment in full.** Members are responsible for any balance of billed out-of-network provider charges in addition to the Member's coinsurance amount.

Change in Dependent Eligibility During the Plan Year: To add a new dependent to your coverage, you must complete a Health Care Coverage Change Form and submit it to the Benefits Department within 90 days of the date the dependent gains eligibility. If one of your dependents loses eligibility (e.g., you divorce or your child turns age 26), you must complete a Health Care Coverage Change Form and submit it to the Benefits Department within 90 days of the date of the event, to remove the ineligible person from your coverage. The University cannot refund overpayments due to IRS Regulations, so please submit your form as soon as possible. In order for the dependent to be eligible for COBRA Continuation Coverage, the form must be submitted within **60** days from the date of the event.

Privacy Policy: The Plan is required to follow strict federal and state laws regarding the confidentiality of protected health information ("PHI"). The Plan's Notice of Privacy Practices describes the Plan's practices relating to PHI and the rights members have concerning their PHI. The Notice of Privacy Practices is available online at www.hr.utah.edu/ben/privacy. To obtain a copy by mail, contact the Benefits Department at (801) 581-7447.

Social Security Numbers: The University is required to identify individuals enrolled in health coverage to the IRS. This will ensure that health plan members are not assessed a penalty under Health Care Reform for the time they were enrolled in the University's plan. Please provide social security numbers for all dependents enrolled in the health care plan.

Coverage of Eligible Dependents: The University will take corrective action against employees who (a) enroll an individual in the Health Care Plan that they know or should know is ineligible and/or (b) file claims (either directly or indirectly through a health care provider) for an individual that they know or should know is ineligible for coverage under the Plan. Corrective action includes termination of employment, legal action for reimbursement of all claims, and cancellation of coverage without the right to elect COBRA continuation coverage.

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

Wellness Program 2016 Plan Year

PROGRAM REQUIREMENTS

Complete July 1, 2015 – June 30, 2016

To participate in the WellU Program during the 2016 Plan Year (7/1/2016 through 6/30/2017), you must complete the program requirements **prior to June 30, 2016**.

Annual Physical or Wellness Exam

Talk with your provider about appropriate preventive screenings.

Two WellU Wellness Activities

Complete any two different WellU Wellness Activities prior to June 30, 2016. (See below)

New Employees hired **January 1, 2016 through March 31, 2016** must complete the **General Health Assessment** (GHA) to participate and receive the discount for the remainder of the current Plan Year. To participate and receive the discount for the upcoming Plan Year beginning July 1, 2015, an annual physical or wellness exam is required on or before June 30. New Employees hired **April 1, 2016 through June 30, 2016** must complete the GHA to participate and receive the discount for the remainder of the current Plan Year, as well as the next Plan Year (through June 30, 2016).

WellU Wellness Activities (Continues on page 2)

Health Care Provider

Obtain these services from a health care provider of your choice – they *must* be billed through the health plan to receive credit for completion of the option.

Dental Cleaning and Exam

Flu Shot

Employee Appreciation Day flu clinic and flu clinics arranged through/reported by your department will count toward this requirement.

Cervical Cancer Screening (women)

Mammogram (women)

Osteoporosis Screening (women)

Prostate Cancer Screening (men)

Colorectal Cancer Screening

Campus Recreation Services

Campus Recreation membership required – employee pays fitness class fees

Pretraining Assessment

The assessment will measure resting blood pressure/heart rate, cardiovascular endurance, muscular strength and endurance, flexibility, and body composition

Work out or take a fitness class.

Work out at the new Eccles Student Life Center and tap your ID card when you access the facility. The first six taps on different days will count as completion of one participation option. Fitness classes include Ballet Barre, Boot Camp, Cycling, Pilates, TRX, Turbokick, Yoga, and Zumba.

Continuing Education

Visit **www.continue.utah.edu/wellu** for a complete list of eligible classes or to register for classes.

Lifelong Learning

Classes include Pilates, Yoga, Acupressure, Meditation Sampler, Nutrition 101, and many more

Academic Noncredit

Classes include Ballet, Swimming, Cycling, Crossfit, Tennis, and many more

(Employees must pay any fees required for each class or workshop. To receive WellU credit, you must notify your instructor on the first day of class that you are participating in the WellU program. You will need to attend classes at least 6 times, and sign the roll each class session or make sure the instructor is taking attendance. Complete two three-session classes to receive credit for completion of one participation option. Full-time employees may qualify for tuition reduction for Continuing Education Classes. Credit will be given at the end of the class or workshop if attendance requirements have been met.)

PEAK Health and Fitness

and

University Health and Wellness Center

Employee pays fitness class fees

A Mindfulness Approach to Work/Life Balance

Come learn effective coping tools for navigating the responsibilities of different life roles as well as techniques for managing stress and anxiety. This is a six week, 1 hour per week workshop. Dates TBA.

Bod Pod Body Composition Measurement

Provides precise body composition measurement quickly and comfortably, includes a brief consultation with a PEAK professional to explain results.

Diabetes Prevention Program

Are you at risk for diabetes? Come join a group of your peers for an evidence-based 16-visit, 12 month education and lifestyle modification program for staff and faculty. Multiple locations available. Dates TBA (Employees must pay fees required for the program.)

Fitness Assessment

A series of measurements that help determine physical fitness including the following: cardiovascular fitness, flexibility and strength.

Fitness Classes

Classes include Aquatone, Bootcamp, Circuit Training, Core Training, Express Classes, Functional Fitness, Indoor Cycling, Pilates Mat, Running Speed Work, Stretch & Strength, Swimming for Fitness, Weight Training, and Yoga. (Employees must pay any fees required for fitness classes.)

Focused Nutrition Consultation

General and preventive nutrition information, plus several specialty areas including family/child health and nutrition, sports nutrition, hypertension control, cholesterol lowering, weight loss and maintenance, cardiovascular nutrition, bone health, diabetes management, and others, personalized to your health needs. Includes Resting Metabolic Rate measurement.

Health and Wellness Coaching

Coaches will assist you in optimizing your health with evidenced-based lifestyle solutions tailored to your desires whether it is time and stress management, weight maintenance or loss, or specific goal setting.

Nutrition Workshops (Variety of topics)

Personal Training/Exercise Prescription

Individualized exercise program tailored to meet your goals and your health and fitness needs; may include weight loss and maintenance, functional fitness, strength training, aerobic and anaerobic conditioning, and sports specific training.

Weight Management Consultation

Work with a dietitian to develop a strategy to safely meet your weight loss goals; includes in-depth analysis of 1-day diet record, individualized diet plan for successful weight loss, and goal setting relative to weight loss. Includes Resting Metabolic Rate measurement.

You may choose any two (2) different Campus Recreation, PEAK Health and Fitness or University Health and Wellness Center options at no cost (excluding fitness classes). For Campus Recreation Services activities a membership is required. If you choose one or two of the Health Care Provider options to receive the discount, your spouse or dependent over age 18 may use one or both of your remaining community partner options. Use of the community partner options by your spouse or dependent will not count as completion of a participation option for the WellU Program.

Campus Recreation Services
Eccles Student Life Center
1836 Student Life Way
Salt Lake City, Utah 84112
801-581-8898

Continuing Education
www.continue.utah.edu/wellu
1901 E South Campus Dr. #1215
Salt Lake City, UT 84112
801-581-6461

PEAK Health and Fitness
250 S. 1850 E. (HPER East 217)
Salt Lake City, UT 84112
801-585-7325

UUHC Health & Wellness Center
295 Chipeta Way
Salt Lake City, Utah 84108
801-213-3777

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Name				Empl ID#
Address	City	State	Zip	Daytime Phone ( )

The University's Plan Year begins on July 1 and runs through the following June 30

A flexible spending account ("FSA") allows employees to be reimbursed with pre-tax dollars for qualifying out-of-pocket health care expenses for you and your eligible dependents and/or dependent 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 90 days 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 date of participation for a newly eligible employee (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 enroll, change or cancel elections during the Plan Year if they experience a qualified status change event consistent with the requested change. **Eligible changes to an FSA election must be requested within 90 days of the date of the status change event or prior to the end of the Plan Year (June 30), whichever occurs first**.

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 $2,550 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year.

Eligible medical expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease or to affect any structure or function of the body.

You may request reimbursement for eligible medical expenses incurred on behalf of yourself, your spouse, and your dependent children.

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 Code limits the amount you may defer to a Dependent Care FSA to $5,000 per calendar year per family.

Expenses are eligible 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, resides with you for more than one-half of the calendar year, and is/could be your tax dependent.

To *estimate* your per paycheck amount, complete the worksheet on the back of this form.

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 90 days of the event date or prior to the end of the Plan Year, whichever is earlier.
- To be eligible, expenses must not be paid, reimbursed, or reimbursable from any other source.
- 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 incurred on or before the end of the grace period [September 15] and submitted no later than December 31 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 ASI Flex for reimbursement of unreimbursed health and/or dependent care expenses. If I use my Flex Funds Debit Card for Health FSA purchases, I will not need to submit my receipt to ASI Flex unless asked to verify that the expense was an eligible expense.
- I agree to use my Flex Funds Debit Card for eligible Health FSA expenses that have not already been reimbursed and will not seek reimbursement of those expenses from any other source.

I have read and understand the above 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 for the Plan Year.

Employee Signature: _____ **Date:** _____

Benefit Dept. Use Only	**Entry Date:**	**Entered By:**	**QC By:**	**QC Date:**

To ***estimate*** your per paycheck deduction, complete the following worksheet. Eligible expenses must be incurred on or before September 15 following the end of the Plan Year (the University's 45-day grace period).

For information or assistance, contact the Benefits Department at (801) 581-7447.

	Health FSA	**Dependent Care FSA**
Annual Election	$_____	$_____
Number of Pay Periods Remaining in Plan Year	÷ _____	÷ _____
Per Paycheck Deduction	$_____	$_____

IMPORTANT!

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

For details on eligible expenses, reimbursement request forms, and other FSA information, see ASI Flex's website at www.asiflex.com.

SHORT TERM AND LONG TERM DISABILITY INSURANCE

Name:	Empl ID#:

Employees who enroll during their Initial Enrollment Period (first 90 days following date of hire into a benefit-eligible position), will not be required to provide evidence of good health. Employees who wish to enroll after their Initial Enrollment Period must use a different form and will be required to apply and provide evidence of good health.

Premiums differ based on your employer-funded retirement plan and are calculated using your compensation (see reverse side to calculate your premium). ***Coverage elected during your Initial Enrollment Period will become effective retroactive to your date of hire or transfer to a position that is newly eligible for benefits and retroactive premiums will be deducted.***

The Certificates of Insurance includes all coverage details. See the Disability Insurance page on the Benefits Department's website at www.hr.utah.edu/benefits.

Short Term Disability Insurance

This optional insurance provides enrolled employees who have an eligible disability with up to 60% income replacement up to a maximum of $5,000 per week, less certain income from other sources. Benefits become payable after a 90-day waiting period for up to a maximum of 90 days (when LTD benefits begin).

I WISH TO ENROLL IN SHORT TERM DISABILITY INSURANCE **To enroll in Short Term Disability Insurance, you must also enroll in Long Term Disability Insurance.*	**[ ] ENROLL [ ] WAIVE**

Long Term Disability Insurance

This optional insurance provides enrolled employees who have an eligible disability with up to 60% income replacement up to a maximum of $25,000 per month, less certain income from other sources. Benefits become payable after a 180-day waiting period. Benefits and premium rates differ based on the University-funded retirement plan in which the employee is enrolled and whether the employee's position is full-time or part-time. Practicing physicians are enrolled in separate category of coverage, which has its own premium and a specialty-specific definition of disability. For assistance in estimating your premium, please contact the Benefits Department at (801) 581-7447.

I WISH TO ENROLL IN LONG TERM DISABILITY INSURANCE ** You may enroll in Long Term Disability Insurance without enrolling in Short Term Disability Insurance.*	**[ ] ENROLL**

I have read and understand the information provided. I acknowledge that the terms of the Policy and Insurance Certificate will apply, including the fact that I must be actively at work before my coverage will begin, and that I must review the Policy for the specific terms and conditions of the coverage. I hereby apply for coverage as indicated above and authorize the University to make the appropriate deductions from my wages to pay premiums. 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.

Employee Signature: _____ Date: _____

[ ] Practicing physician

University of Utah Division of Human Resources – Benefits Department
420 Wakara Way, Suite 105 **(801) 581-7447**
Salt Lake City, UT 84108 **Fax: (801) 585-7375**

Entered By: _____ QC By: _____
Date: _____

PREMIUM CALCULATIONS

Short Term Disability		
To calculate your expected monthly premium, use the following table:		
Monthly Wage not to exceed $36,166.67 (Annual Salary divided by 12)	$	
Multiply by Premium Rate	x	0.00135
Monthly Premium (will be deducted one-half on 7th and one-half on 22nd of each month)	$	

Long Term Disability: To calculate your monthly LTD insurance premium, choose the box below that corresponds with the University-funded retirement plan in which you are enrolled[1]. If you are a practicing physician, use the box at the bottom. Contact the Benefits Department at (801) 581-7447 if you are unsure which box applied to you.

Long Term Disability - 401(a) Defined Contribution Retirement Plan and Utah Retirement Systems– Tier II (Participation began 7/1/2011 or after)		
To calculate your expected monthly premium, use the following table:		
Monthly Wage not to exceed $41,666.67 (Annual Salary divided by 12)	$	
Multiply by Premium Rate	x	0.00456
Subtotal:	$	
Subtract University Contribution: $8 (75% FTE or greater) or $4 (50% to 74% FTE)	-	
Monthly Premium (will be deducted one-half on 7th and one-half on 22nd of each month)	$	

Long Term Disability – Utah Retirement Systems– Tier I (Participation began prior to 7/1/2011)		
To calculate your expected monthly premium, use the following table:		
Monthly Wage not to exceed $41,666.67 (Annual Salary divided by 12)	$	
Multiply by Premium Rate	x	0.00332
Subtotal:	$	
Subtract University Contribution: $8 (75% FTE or greater) or $4 (50% to 74% FTE)	-	
Monthly Premium (will be deducted one-half on 7th and one-half on 22nd of each month)	$	

Long Term Disability – Practicing Physicians only		
To calculate your expected monthly premium, use the following table:		
Monthly compensation including CIP up to $41,666.67 (Annual Salary divided by 12)	$	
Multiply by Premium Rate	x	0.00728
Approximate Monthly Premium (Actual premium will be calculated on compensation received each pay period)	$	

[1] *If you are not eligible for University-funded retirement, use the URS Tier I calculation and rate.*

LIFE INSURANCE ENROLLMENT FORM

THE UNIVERSITY OF UTAH

Name		Employee ID#

Life Insurance Coverage through The Hartford

See the Benefits Department's website at www.hr.utah.edu/benefits or contact the Benefits Department at (801) 581-7447 for coverage details

Please indicate beneficiary designations on the back of this form.

Part I

Life insurance in the amount of your annual salary up to a maximum of $25,000.

Automatically provided to employees in benefit-eligible positions by the University at no cost to the employee.

Part II

Life Insurance in the amount of your annual salary up to a maximum of $25,000. Rate information is included on page 3 of this form.

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.

Enroll [ ] Yes [ ] No

Employee Supplemental Term Life Insurance

Minimum of $20,000 up to maximum of $500,000 (or five times your annual salary up to $750,000) in $5,000 increments.

If you enroll during your Initial Enrollment Period (first 90 days following your date of hire into a benefit-eligible position with the University), you may enroll in coverage up to $350,000 without providing evidence of insurability. If you would like additional coverage or are enrolling after your Initial Enrollment Period, you must complete the Life Insurance Personal Health Application.

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

Amount of Employee Supplemental Term Life Insurance Coverage:

$_____

Spouse Supplemental Term Life Insurance

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). You must be enrolled in Supplemental Term Insurance or have applied for enrollment to participate in this option.

If you enroll during your Initial Enrollment Period (first 90 days following your date of hire into a benefit-eligible position with the University), you may enroll in coverage up to $30,000 without providing evidence of insurability. If you would like additional coverage or are enrolling after your Initial Enrollment Period, you and your spouse must complete the Life Insurance Personal Health Application.

Spouse's Birthday (Month/Day/Year): _____

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

Amount of Spouse Supplemental Term Life Insurance Coverage:

$_____

Dependent Child Supplemental Term

[ ] $5,000 [ ] $10,000

You must be enrolled in Supplemental Term Insurance or have applied for enrollment to participate in this option.

I have read and understand the insurance coverage information on this form and in the Your Benefit Plan booklet. I understand that coverage is provided pursuant to a Certificate of Insurance issued by The Hartford. I understand The University of Utah intends for this program to continue into the future; however, The University of Utah reserves the right to change, modify, terminate, or cancel this or any subsequent program. This program is insured by The Hartford. The University of Utah is not liable for claims or any other payments required to be made by The Hartford. The University's only responsibilities are the selection of the insurance carrier, the administration of the program, and the payment of the University's share of premiums described herein. If the insurance company fails to perform its obligations, the covered person's sole remedy will be to pursue his/her rights against The Hartford. 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:** _____

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

University of Utah Division of Human Resources – Benefits Department
420 Wakara Way, Suite 105 (801) 581-7447
Salt Lake City, UT 84108 Fax: (801) 585-7375

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, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Part III	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse/Parent	100
Contingent Beneficiary(ies)			

Employee Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Spouse Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse	100
Contingent Beneficiary(ies)			

Dependent Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Parent	100
Contingent Beneficiary(ies)			

I certify that these are my beneficiary designations for the life insurance I elected on the reverse side of this form.

Employee Signature: _____ **Date:** _____

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

University of Utah Group Life Insurance
Underwritten by Hartford Life and Accident Insurance Company
Monthly Premium Rates Effective July 1, 2015

Part II Basic Employee Life Insurance
$.15 per $1,000 of coverage

Part III Basic Dependent Life Insurance
$.33 per month

Dependent Child Supplemental Term Life Insurance
$.60 for coverage in the amount of $5,000
$1.20 for coverage in the amount of $10,000

Employee and/or Spouse Supplemental Term Life Insurance
Choose your desired coverage amount (in increments of $5,000 - minimum $20,000)
Monthly premium rate per $1,000 of coverage:

Age	Non-tobacco User	Tobacco User	Age	Non-tobacco User	Tobacco User
Under 30	$ 0.045	$ 0.076	62	$ 0.594	$ 1.180
30	$ 0.054	$ 0.084	63	$ 0.594	$ 1.281
31	$ 0.054	$ 0.092	64	$ 0.594	$ 1.339
32	$ 0.054	$ 0.092	65	$ 0.829	$ 1.524
33	$ 0.054	$ 0.092	66	$ 0.913	$ 1.657
34	$ 0.054	$ 0.101	67	$ 1.004	$ 1.791
35	$ 0.072	$ 0.109	68	$ 1.096	$ 1.950
36	$ 0.072	$ 0.109	69	$ 1.143	$ 2.101
37	$ 0.072	$ 0.126	70	$ 1.499	$ 2.486
38	$ 0.072	$ 0.126	71	$ 1.758	$ 2.849
39	$ 0.072	$ 0.126	72	$ 1.854	$ 3.130
40	$ 0.081	$ 0.150	73	$ 1.854	$ 3.490
41	$ 0.081	$ 0.159	74	$ 1.854	$ 3.901
42	$ 0.081	$ 0.185	75	$ 1.854	$ 4.370
43	$ 0.081	$ 0.193	76	$ 1.854	$ 4.921
44	$ 0.084	$ 0.210	77	$ 1.854	$ 5.415
45	$ 0.117	$ 0.226	78	$ 1.854	$ 5.901
46	$ 0.122	$ 0.243	79	$ 1.854	$ 6.428
47	$ 0.122	$ 0.276	80	$ 1.854	$ 7.023
48	$ 0.122	$ 0.302	81	$ 1.854	$ 7.683
49	$ 0.135	$ 0.335	82	$ 1.854	$ 8.429
50	$ 0.159	$ 0.377	83	$ 1.854	$ 9.283
51	$ 0.185	$ 0.427	84	$ 1.854	$ 10.262
52	$ 0.201	$ 0.469	85	$ 1.854	$ 11.040
53	$ 0.207	$ 0.527	86	$ 1.854	$ 11.928
54	$ 0.207	$ 0.603	87	$ 1.854	$ 12.848
55	$ 0.302	$ 0.636	88	$ 1.854	$ 13.744
56	$ 0.318	$ 0.695	89	$ 1.854	$ 14.639
57	$ 0.352	$ 0.761	90	$ 1.854	$ 15.585
58	$ 0.387	$ 0.829	91	$ 1.854	$ 16.639
59	$ 0.387	$ 0.904	92	$ 1.854	$ 17.803
60	$ 0.485	$ 0.987	93	$ 1.854	$ 19.058
61	$ 0.545	$ 1.088	94	$ 1.854	$ 20.306
			95	$ 1.854	$ 21.494

To calculate premium cost: Determine the premium rate that applies to your age and tobacco use. Divide your desired coverage amount by 1,000, then multiply that number by the premium rate. *For example, assume you are age 45, do not use tobacco, and want $150,000 of coverage. Your premium rate would be $.117 per $1,000 of desired coverage ($.117 multiplied by 150), for a total premium of $17.55 per month.*

ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM

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

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. Dual coverage is not allowed—you may not be enrolled as an employee and a spouse or dependent of another University employee. (See Plan booklet for specific details. Plan booklet is available on the University's AD&D web page at www.hr.utah.edu/benefits)

You may enroll at any time. Proof of good health is not required. Coverage elected during your Initial Enrollment Period will become effective retroactive to the date of hire or transfer to a position that is newly eligible for benefits and retroactive premiums will be deducted. Coverage elected after your Initial Enrollment Period is effective on the first day of the month on or following the date your completed enrollment form is submitted to the Benefits Department.

AD&D Policy Elections:

Coverage Level	Coverage Amount
[ ] Employee Only ($.14 per $10,000 of coverage) [ ] Family Coverage ($.28 per $10,000 of coverage)	Coverage Amount: $_____ *Enter amount in $10,000 increments* *(Minimum $10,000 / Maximum $500,000)*

Beneficiary Elections

Primary Beneficiary:	Relationship to Employee:
Contingent Beneficiary:	Relationship to Employee:

(Employee is always the beneficiary for coverage on family members. If you wish to elect more than one primary or contingent beneficiary, please indicate them on a separate sheet and attach it to this form.)

Certification

I wish to enroll in Accidental Death and Dismemberment Insurance through the University of Utah. I certify the information I have provided on all parts of this form is true and correct. I understand coverage will be effective the first day of the month following the date I submit my completed form to the University Benefits Department or on the day I submit my form if it is the first day of the month. I hereby authorize payroll deductions of premiums as required.

Employee Signature: _____ Date: _____

For detailed plan information, please refer to the official Policy document. Information and documents are available on the internet at www.hr.utah.edu/benefits or in the Benefits Department.

University of Utah Benefits Department: 420 Wakara Way, Ste. #105, Salt Lake City, UT 84108
Phone: (801) 581-7447, Fax: (801) 585-7375, e-mail: benefits@utah.edu

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

ADDITIONAL BENEFITS ENROLLMENT INFORMATION

Home & Auto Insurance

(Liberty Mutual, MetLife Home and Auto & Safeco Insurance)

University employees may enroll in home and auto insurance at group rates through the University. The University has partnered with three companies to provide this coverage: Liberty Mutual Insurance, MetLife Home and Auto, and Safeco Insurance.

HOW TO ENROLL:
If you enroll in coverage through the University, premiums will be deducted directly from your paychecks. To obtain quotes or receive additional information on available coverage, contact the respective company:

Liberty Mutual Insurance
visit http://www.libertymutual.com/uemployees
or Call **1-800-524-9400** (mention client # 119937)

MetLife Home and Auto & **Safeco Insurance**
Call **1-877-638-7515**

Discounts and savings are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Please consult a sales representative for additional information.

The University does not guarantee that rates provided by any of these companies will be the best rate available to you.

Hyatt Legal Plans

Hyatt Legal Plans is an affordable solution to help you with your legal needs. The Group Legal Plan, administered by Hyatt Legal Plans, gives you access to legal representation or advice for a wide range of legal matters. Covered legal services include:

- Wills and Estate Planning
- Debt Matters
- Defense of Civil Lawsuits
- Reduced Fees
- Real Estate Matters
- Consumer Protection
- Document Review
- Juvenile Matters
- Family Law
- Document Preparation
- Traffic Matters

To get an up-to-date listing of participating attorneys (including attorneys outside the state of Utah) and covered services, go to www.legalplans.com. Once on the website current participants can go to "Members Log In". Employees who are not current members or who have not set up a member login can go to "Thinking About Enrolling" and use 4940030 as the password.

HOW TO ENROLL:
If you wish to enroll, visit http://www.metlife.com/mybenefits or call **1-800-GET-MET 8** (800) 438-6388. Enrollment is automatically continued unless you cancel your enrollment during open enrollment (cancellation will be effective June 30).

Long Term Care Insurance *(CNA)*

Long-term care is the kind of care people need when, because of severe injury or chronic illness, they cannot perform basic activities of daily living without help. Long-term care isn't just for the elderly; disabling injuries can occur at any age. A disabling illness or injury might mean needing help in your home to do basic activities, such as bathing and dressing, or needing full-time nursing home assistance.

The cost of long-term care can range from $30,000 to $100,000 per year, and those costs are typically not paid by other insurance. Medical insurance only pays for short-term acute care. Disability insurance pays a percentage of your regular salary while you are unable to work. Medicare will only pay for limited amounts of care. Medicaid does pay for long-term care; however, only after you spend most of your financial assets.

HOW TO ENROLL:
The University of Utah sponsors Long-Term Care Insurance through CNA. Information regarding plan options and premiums is available by contacting at CNA at **1-800-528-4582** or visit the following webpage:
http://www.ltcbenefits.com/start.asp?account=32021347&user_id=uofutahqltc

403(b) Plan Salary Reduction Agreement

THE UNIVERSITY OF UTAH

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

☐ New Participation in the Plan ☐ Replace Existing Agreement ☐ Cancel Salary Reduction

Contribution Amounts

I wish my contributions to begin:	☐ 1st Paycheck (7th of the month) ☐ 2nd Paycheck (22nd of the month)	Month:_____ Year:_____

Each pay period I wish to contribute: *(See back of this form for minimum and maximum contribution and Roth information)*

Pre-Tax Contribution:	$_____ **OR** _____% of my pay	I qualify and wish to use *(choose one or both options)*: ☐ 15-Year Catch-up Provision *(must be used first if eligible)* ☐ Age 50 Catch-up Provision
After-Tax Roth Contribution:	$_____ **OR** _____% of my pay	

Investment Provider(s)

I hereby instruct The University of Utah to direct the following percentages of the amount shown above to an account in my name with the following Investment Provider(s):

Investment Provider	Percent to Defer
Fidelity Investments	%
TIAA-CREF	%

The numbers above must be in whole percents only and must total 100%. If you wish to invest all funds with one Provider, write 100%.

CERTIFICATION

I hereby understand and certify as follows:

- I wish to participate in the University of Utah 403(b) Tax-Deferred Annuity Plan (the "Plan"). I hereby authorize and direct the University to reduce my compensation by the amount shown above and to remit such amount to the Investment Provider(s) identified above. I understand that my total deferrals for each calendar year cannot exceed the maximum set by the Internal Revenue Code and that it is my responsibility to monitor compliance with these rules.
- I understand that this salary reduction agreement ***revokes and replaces*** any 403(b) Plan Salary Reduction Agreement which I have previously signed. I understand that the amount stated above will be ***deducted each pay period***. This Salary Reduction Agreement is irrevocable with respect to amounts deferred while the Agreement is in effect. It will remain in effect until replaced with a different Salary Reduction Agreement or cancelled in writing. If, as a result of an error, amounts are not withheld in accordance with this election, and if I fail to notify the Benefits Department of the error within three months measured from the date of the first paycheck that fails to properly withhold the correct amount then, effective as of that date, I will be deemed to have made an affirmative election equal to the amount that is actually then being deducted from my paychecks.
- I understand that unless I contact the Investment Provider and request different investment choices for my account, the funds will be invested in a target retirement date life-cycle fund based on my current age and anticipated retirement at age 65. I understand that I may change my investment options at any time by contacting the Investment Provider. I assume responsibility for reading and understanding the materials provided by the Investment Providers regarding available investments options.
- I understand that this change only affects money that will be sent by the University after this form is processed in the Benefits Department. If I wish to transfer funds from one Provider to another, I must contact the new Provider to initiate the transfer.
- I understand that I may not access funds contributed to my account until the first to occur of the following events: (a) I reach age 59½; (b) I retire from the University, (c) my employment with the University has been terminated for 32 days or more; or (d) I experience an eligible hardship. Roth contributions are subject to a 5-year holding period (see the back of this form for info.) I understand that pre-tax amounts I withdraw will be subject to taxes and all amounts withdrawn may be subject to IRS penalties depending on my age at the time of withdrawal and whether I have met the 5-year holding period for Roth deferrals.
- I understand and acknowledge the Benefits Department cannot give me tax or investment advice regarding my retirement account(s); I can obtain information and advice through my Investment Provider.

Employee Signature: _____ Date: _____

The University of Utah Human Resources Division – Benefits Department
420 Wakara Way, Suite 105, Salt Lake City, UT 84108 Phone: (801) 581-7447 ~ Fax: (801) 585-7375

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

UNIVERSITY OF UTAH 403(b) TAX-DEFERRED ANNUITY PLAN
Salary Reduction Agreement Form Instructions

All employees of the University of Utah receiving compensation may participate in the University of Utah 403(b) Tax-Deferred Annuity Plan (the "Plan"). Contributing to the Plan is a major financial decision. **This Plan is not a typical savings account**—there are restrictions regarding when you can have access to money deferred into a 403(b) account. Contact the University's Benefits Department or one of the Investment Providers if you have any questions about participating in the Plan. You may also want to consult a tax advisor before making a final decision to participate. **The Internal Revenue Code limits the amount that may be contributed to the Plan and imposes penalties for excess contributions. It is therefore important to carefully consider how much to contribute. The limits are discussed below.**

Minimum/Maximum Contribution Amounts: The minimum amount that may be contributed is $12.50 per investment provider per pay period. Unless you qualify for one of the Catch-up Provisions described below, the maximum amount you may contribute (either pre-tax, after-tax Roth, or combined) to a 403(b) Plan (**including 403(b) and 401(k) plans with other employers**), cannot exceed Internal Revenue Code limits outlined below:

Year	Maximum Contribution
2015	$18,000.00
2016	$18,000.00

After-Tax Roth Contributions: After-tax contributions are irrevocably designated "Roth contributions" when the deferral is made and will be maintained by the Investment Provider(s) in an account separate from pre-tax contributions. Your income is taxed before Roth contributions are deferred. Qualified Distributions of Roth contributions and any earnings on those contributions are not subject to federal tax and may not be subject to state tax and many other states when withdrawn. You may wish to consult a tax practitioner to discuss your particular situation. To be a Qualified Distribution the Roth account must have been open for at least 5 tax years (the 5-year holding period begins the first tax year for which a Roth contribution is made to the Plan or the first tax year Roth amounts are made to another employer's Plan which are subsequently rolled over into the University's 403(b) Plan), and (a) you are at least age 59½, (b) you have a qualified disability, or (c) the distribution is made to your beneficiary on or after your death.

Catch-Up Provisions: If you are eligible, you may take advantage of both Catch-up Provisions simultaneously.

15-Year Catch-up Rule: You may be able to exceed the Maximum Contribution amount shown above if you have 15 years of full-time equivalent service with The University of Utah. Contributions made under the 15-Year Catch-up have a lifetime maximum. Contact the Benefits Department or your Investment Provider for information and to see if you are eligible to take advantage of this catch-up.

Age 50 Catch-up Rule: If you are or will be age 50 or older during the year, you may contribute an additional amount up to $6,000 per year (2015 and 2016). (This amount may be increased in future years.)

To Open An Account: If you do not have a University 403(b) Plan account with the respective investment provider when your first deferral is sent, an account will be opened in your name and funds will be invested in a target retirement date life cycle fund based on your age and anticipated retirement at age 65. To open an account with your chosen investment provider and select investment options go to www.hr.utah.edu/benefits/retirement.php.

To Change Your Investment Options: You may change your investment options at any time. Contact the investment provider's customer service department or make changes online through the investment provider's website. A few funds may be subject to a Redemption/Short Term Trading Fee.

To Transfer Your Assets From One Investment Provider To Another: Contact the investment provider you want to transfer your assets to. Complete the provider's asset transfer form and send your completed form to the new investment provider. The new provider will contact your current provider and arrange the transfer.

Investment Providers

Fidelity Investments
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860
www.plan.fidelity.com/uofu

TIAA-CREF
420 Wakara Way, Suite 200
Salt Lake City, Utah 84108
Phone: 801-883-5100 (in SLC) or 1-800-842-2252
www.tiaa-cref.org/uofu

457(b) Plan Salary Reduction Agreement

THE UNIVERSITY OF UTAH

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

☐ New Participation in the Plan ☐ Replace Existing Agreement ☐ Cancel Salary Reduction

Contribution Amounts

Participation in the Plan will begin on the 1st of the month following the date this completed form is submitted to the Benefits Department (the first deferral will be from the paycheck received on the 7th of that month). Changes to or cancellation of participation will be effective for the pay period in which the form is received. If you wish this agreement to be effective later, please indicate the month and year: _____

Each Pay Period I wish to contribute: *(See back of this form for minimum and maximum contribution information)*

Pre-Tax Contribution:	$_____OR_____% of my pay	I qualify and wish to use *(choose only 1)*: ☐ Age 50 Catch-up Provision ☐ Underutilization Catch-up Provision
After-Tax Roth Contribution:	$_____OR_____% of my pay	

Investment Provider(s)

I hereby instruct The University of Utah to direct the following percentages of the amount shown above to an account in my name with the following Investment Provider(s):

Investment Provider	Percent to Defer
Fidelity Investments	%
TIAA-CREF	%

The numbers above must be in whole percents only and must total 100%. If you wish to invest all funds with one Provider, write 100%.

CERTIFICATION

I hereby understand and certify as follows:

- I wish to participate in the University of Utah 457(b) Plan (the "Plan"). I hereby authorize and direct the University to reduce my compensation by the amount shown above and to remit such amount to the Investment Provider(s) identified above. I understand that my total contributions for each calendar year cannot exceed the contribution limits set by the Internal Revenue Code and that it is my responsibility to monitor compliance with these rules.
- I understand that this salary reduction agreement ***revokes and replaces*** any 457(b) Plan Salary Reduction Agreement which I have previously signed. I understand that the contributions will be ***deducted each pay period***. This Salary Reduction Agreement is irrevocable with respect to amounts paid while the Agreement is in effect. It will remain in effect until replaced with a different Salary Reduction Agreement or cancelled in writing. If, as a result of an error, amounts are not withheld in accordance with this election, and if I fail to notify the Benefits Department of the error within three months measured from the date of the first paycheck that fails to properly withhold the correct amount then, effective as of that date, I will be deemed to have made an affirmative election equal to the amount that is actually then being deducted from my paychecks.
- I understand that unless I contact the Investment Provider and request different investment choices for my account, the funds will be invested in a target retirement date life-cycle fund based on my current age and anticipated retirement at age 65. I understand that I may change my investment options at any time by contacting the Investment Provider. I assume responsibility for reading and understanding the materials provided by the Investment Provider regarding investment options.
- I understand that this agreement only affects money sent by the University after this form is processed in the Benefits Department. If I wish to transfer funds from one Provider to another, I must contact the new Provider to initiate the transfer process.
- I understand that I may not access funds contributed to my account until the first to occur of the following events: (a) I reach age 70½; (b) I retire from the University, (c) my employment with the University has been terminated for 32 days or more; or (d) I experience an eligible hardship. Roth contributions are subject to a 5-year holding period (see the back of this form for info.) I understand that pre-tax amounts I withdraw will be subject to taxes and all amounts withdrawn may be subject to IRS penalties depending on my age at the time of withdrawal and whether I have met the 5-year holding period for Roth deferrals.
- I understand and acknowledge the Benefits Department cannot give me tax or investment advice regarding my retirement account(s); I can obtain information and advice through my Investment Provider.

Employee Signature: _____ Date: _____

The University of Utah Human Resources Division – Benefits Department
420 Wakara Way, Suite 105, Salt Lake City, UT 84124 Phone: (801) 581-7447 ~ Fax: (801) 585-7375

Benefits Dept. Use Only > *New agreement effective 16th of month*	Entry Date:	Entered By:	QC By:

UNIVERSITY OF UTAH 457(b) PLAN
Salary Reduction Agreement Form Instructions

All employees of the University of Utah receiving compensation may participate in the University's 457(b) Plan (the "Plan"). Contributing to the Plan is a major financial decision. **The Plan is not a typical savings account**—there are restrictions regarding when you can have access to money deferred into a 457(b) account. Contact the University's Benefits Department or either of the Investment Providers if you have any questions about participating in the Plan. You may also want to consult a tax advisor before making a final decision to participate. **The Internal Revenue Code limits the amount that may be contributed to the Plan and imposes penalties for excess contributions. It is therefore important to carefully consider how much to contribute. The limits are discussed below.**

After-Tax Roth Contributions: After-tax contributions are irrevocably designated "Roth contributions" when the deferral is made and will be maintained by the Investment Provider(s) in an account separate from pre-tax contributions. Your income is taxed before Roth contributions are deferred. Qualified Distributions of Roth contributions and any earnings on those contributions are not subject to federal tax and may not be subject to state tax when withdrawn. You may wish to consult a tax practitioner to discuss your particular situation. To be a Qualified Distribution the Roth account must have been open for at least 5 tax years (the 5-year holding period begins the first tax year for which a Roth contribution is made to the Plan or the first tax year Roth amounts are made to another employer's Plan which are subsequently rolled over into the University's 457(b) Plan), and (a) you are at least age 59½, (b) you have a qualified disability, or (c) the distribution is made to your beneficiary on or after your death.

Minimum/Maximum Contribution Amounts: The minimum amount that may be contributed is $12.50 per investment provider per pay period. Unless you qualify for one of the Catch-up Provisions described below, the maximum amount you may contribute cannot exceed Internal Revenue Code limits as outlined below:

Year	Maximum Contribution
2015	$18,000.00
2016	$18,000.00

Catch-Up Provisions: If you are eligible, you may take advantage of either Catch-up Provision. You may not use both Catch-up Provisions in one year.

Age 50 Catch-up Rule: If you are or will be age 50 or older during the year, you may contribute an additional amount up to $6,000 per year (2015 and 2016).

Underutilization Catch-up: During the three years prior to reaching your normal retirement age (age 65 if you are enrolled in the Utah Retirement Systems Program or 59½ if you are enrolled in the 401(a) Defined Contribution Retirement Plan), you may contribute double the Maximum Contribution amount for that year up to the extent you did not contribute the Maximum Contribution amount in prior years (does not include Age 50 Catch-up amounts).

To Open An Account: If you do not have a University 457(b) Plan account with the respective investment provider when your first deferral is sent, an account will be opened in your name and funds will be invested in a target retirement date life cycle fund based on your age and anticipated retirement at age 65. You may open an account with your chosen investment provider and select investment options prior to the date your first deferral is sent. Information and links are available on the internet at www.hr.utah.edu/benefits/retirement.php.

To Change Your Investment Options: You may change your investment options at any time. Contact the investment provider's customer service department or make changes online through the investment provider's website. A few funds are subject to a Redemption/Short Term Trading Fee.

To Transfer Your Assets From One Investment Provider To Another: Contact the investment provider you want to transfer your assets to. Complete the new provider's asset transfer form and send your completed form to the new provider. The new provider will contact your current provider and arrange the transfer. Check to see if a Redemption/ Short Term Trading Fee applies.

Investment Providers

Fidelity Investments
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860
www.plan.fidelity.com/uofu

TIAA-CREF
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Salt Lake City, Utah 84108
Phone: 801-883-5100 (in SLC) or 1-800-842-2252
www.tiaa-cref.org/uofu

Supplemental Retirement Plans – University of Utah

Are you confident that you are prepared for retirement? If you are not already saving for retirement, why not start today? You can contribute from $12.50 per paycheck up to the maximum allowed by the IRS. If you are already saving, have you calculated how much you will need in retirement to know if you are saving enough? The University offers two supplemental retirement plans for employees to use to save for retirement. Here are some of the details about these two plans:

	403(b) Supplemental Retirement Savings Plan	457(b) Supplemental Retirement Savings Plan
Eligibility	All employees receiving compensation through the University payroll system	
Contributions	• You can contribute from $12.50 to 100% of your salary up to the IRS limit of $18,000 to each plan in 2015 and 2016 • Employees age 50 or older can contribute an additional catch-up amount of $6,000 to each plan in 2015 and 2016 • Each plan includes an additional special catch-up option that may be available to employees who have not contributed the maximum in past years	
Contribution Types	Both plans accept pre-tax and/or Roth (after-tax) contributions	
Investment Providers	You may choose to defer pay to an account with Fidelity Investments and/or TIAA-CREF.	
Vesting	You are always 100% vested in your own contributions	
Loans	Loans are available, subject to the rules of the plan; apply for a loan directly through your investment provider	

(Continued on Page 2)

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	403(b) Supplemental Retirement Savings Plan	457(b) Supplemental Retirement Savings Plan
Exchanges	Most plan assets may be transferred within the same plan between the University's investment service providers (Fidelity Investments and TIAA-CREF). Rollovers or Transfers to another plan or individual account are only allowed when the employee qualifies for one of the withdrawal/distribution options (see below)	
Withdrawals / Distributions	• 32 days or more following retirement or termination of employment • Distributions while employed are allowed for employees age 59½ or older, or employees with a qualifying hardship • Withdrawals prior to age 59 ½ may be subject to a 10% IRS penalty • Pretax contributions and associated earnings are subject to income taxes upon withdrawal • Roth contributions and associated earnings are free from federal income tax, provided certain requirements have been met	• 32 days or more following retirement or termination of employment • Distributions while employed are allowed for employees age 70½ or older, or employees with a qualifying hardship • Pretax contributions and associated earnings are subject to income taxes upon withdrawal • Roth contributions and associated earnings are free from federal income tax, provided certain requirements have been met
Accepts Rollovers	Rollovers are accepted from a previous employer's similar retirement plan. Contact your investment service provider for details.	
Counseling Sessions	Fidelity Investments and TIAA-CREF have registered representatives who can meet with you to review investment options and help you determine if you are on track to reach your retirement goals. Individual consultations are provided at no cost to you.	

Fidelity Investments
82 Devonshire Street
Boston, MA 02109
Phone: 1-800-343-0860
www.fidelity.com/atwork/reservations

TIAA-CREF
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www.tiaa-cref.org/schedulenow