SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2012

Network Provider Options		
University Health Care Plus	http://uuhsc.utah.edu/uhealthplan (801) 587-6480 (888) 271-5870	**Category 1** University Health Care Plus Network **Category 2** MultiPlan Network **Category 3** Out-of-network providers
BlueCross BlueShield	www.ut.regence.com/member/doctor www.myregence.com **(**888**)** 370-6159	**Category 1** ValueCare Network **Category 2** BlueCross BlueShield Traditional Network (not also in ValueCare Network) **Category 3** Out-of-network providers

You Control Your Out-of-Pocket Expenses by Selecting Your Provider:

- **Category 1.** You will generally save the most in your out-of-pocket expenses.
- **Category 2.** Your out-of-pocket expenses will generally be a little higher if you see a Category 2 provider because they have not discounted their rates as much as Category 1 providers.
- **Category 3.** These providers do not have a provider discount agreement with the network you select. Payment by the plan will be based on the amount a network provider has agreed to accept for the services. Your out-of-pocket expenses will generally be higher if you use an out-of-network provider. **Also, choosing an out-of-network provider means you may be billed by the provider for amounts that exceed the amount a network provider has agreed to accept as payment in full.**

Plan Design Options

	Advantage	Comprehensive
Annual Maximum Benefit	$2,000,000 per member	$2,000,000 per member
Plan Year Deductible	None	$250 per member $750 per family
Plan Year Medical Maximum Coinsurance	$1,500 per member $4,500 per family	$2,000 per member $6,000 per family

THE AMOUNT YOU PAY FOR COVERED SERVICES:

	Advantage			Comprehensive		
	Cat. 1	**Cat. 2**	**Cat. 3**	**Cat. 1**	**Cat. 2**	**Cat. 3**
	University Hospitals: 0%					
Inpatient Hospital Charges	15%	20%	35%	25%	30%	30%
Emergency Room	$100 copay	$100 copay	35%[1]	25%	25%	30%[2]
Ambulance Services	15%	15%	15%	25%	25%	25%
Lab/X-Ray, Outpatient Hospital, Professional Services	15%	20%	35%	25%	30%	30%
Hearing and Vision Exams ▪ *Limited to one each per Plan Year*	$25 copay	$35 copay	35%	25%	30%	30%
Office Visit	$25 copay	$35 copay	35%	25%	30%	30%

[1] For treatment of an Emergency Medical Condition (as defined in the Summary Plan Description), a Category 3 provider will be paid as a Category 1 provider and you will be responsible for the copay/coinsurance payable to a Category 1 provider.

	Advantage			Comprehensive		
	Cat. 1	**Cat. 2**	**Cat. 3**	**Cat. 1**	**Cat. 2**	**Cat. 3**
Maternity Care	15%	20%	35%	25%	30%	30%
Preventive Services	0%	0%	35%	0%	0%	30%
Preventive Screening Procedures	0%	0%	35%	0%	0%	30%
Neurodevelopmental Therapy ▪ *Children age 6 and under* ▪ *Speech Therapy to age 18* ▪ *Limited to $1,500/Plan Year* *Age and dollar limits do not apply to other covered Speech Therapy Services*	15%	20%	35%	25%	30%	30%
Durable Medical Equipment, Orthotic and Prosthetic Devices	15%	20%	35%	25%	30%	30%
Spinal Manipulation ▪ *Limited to 20 per Plan Year*	$25 copay	$35 copay	35%	25%	30%	30%
Rehabilitation Services ▪ *Inpatient: limited to 30 days per Plan Year*	15%	20%	35%	25%	30%	30%
Prescription Drug Coverage	University Health Care Pharmacies: 20% generic and brand name					
	Other Participating Pharmacies: 25% generic and preferred brands; 35% non-preferred brands					

		Short Term Counseling	**Behavioral Health Services**
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 Employee Assistance Program (EAP)**	No cost to you	INPATIENT Hospital/Professional services: 20% up to 30 days per plan year
			OUTPATIENT office visits: $25 copay up to 20 visits per plan year
	When you <u>do not</u> 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

		Short Term Counseling	**Chemical Dependency Treatment**
Chemical Dependency Services *With or without EAP referral cannot exceed 2 courses of treatment per lifetime*	**When you use the EAP**	No cost to you	INPATIENT services: 20% per course of treatment
			OUTPATIENT services: 20% per course of treatment
	When you <u>do not</u> use the EAP	N/A	INPATIENT services: 50% after $300 deductible per course of treatment
			OUTPATIENT services: 50% per course of treatment

Eyeglasses and Contact Lenses	All University of Utah employees and their eligible family members may receive discounts on LASIK eye surgery, eyeglasses, contact lenses and supplies at the Moran Eye Center. In addition to the special employee discounts, you may now elect payroll deductions for qualifying LASIK procedures done by Moran's vision correction surgeons and up to $1,000 on eyewear at ten community optical locations. Visit <u>http://uuhsc.utah.edu/MoranEyeCenter/patientcare/clinics.html</u> for details.

Dental Coverage Option

Providers	Dental option uses the BlueCross BlueShield Dental Network regardless of which medical network you select. Find participating providers at: www.ut.regence.com/member/doctor. All benefits are paid based on RBCBS schedule of eligible dental expenses.
Deductible	None
Basic Coverage (Exams, X-rays, cleanings, fillings, sealings, periodontics, endodontics)	20% 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	$2,000 per plan year - per member
Orthodontics	$2,000 lifetime per member

Child Eligibility Rules. During Open Enrollment, now through May 18 you may enroll or reenroll your children under the age of 26 (including those who are married or no longer dependent on you.) Coverage for dependents added during Open Enrollment begins July 1, 2012.

Category 3 Out-of-Network coinsurance amounts shown are paid based on Eligible Medical Expenses. **Members may be billed by the 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.

Preexisting Conditions: The Plan has a waiting period for Preexisting Conditions. As of July 1, 2011, the waiting period does not apply to individuals under age 19. The waiting period is 6 months for newly eligible enrollees and late enrollees. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before your Enrollment Date (a) you incurred expenses, received medical treatment, services or advice, underwent diagnostic procedures, took prescribed drugs or medicine, or consulted a physician or other licensed medical professional; or (b) was discovered or suspected as a result of any medical examination, including a routine medical examination. Your Preexisting Condition waiting period will be reduced by any Creditable Coverage.

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.

Change in Dependent Eligibility During the Plan Year: 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 3 months 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. 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 3 months of the date the dependent gains eligibility. The University will take corrective action against Participants 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.

Social Security Numbers: 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, the University needs to provide information, including social security numbers, for all enrolled members.

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.

EMPLOYEE MONTHLY CONTRIBUTION RATES
JULY 1, 2012 THROUGH JUNE 30, 2013

FULL-TIME (75% TO 100% FTE) EMPLOYEE RATES*
Please Note: All rates are **monthly**

		Medical Only			Medical and Dental		
Network Option	Plan Option	Single	Two-Party	Family	Single	Two-Party	Family
University Health Care Plus	Comprehensive	$54.77	$92.53	$124.27	$57.92	$99.77	$135.67
	Advantage	$56.20	$94.96	$127.53	$59.53	$102.20	$138.93
BlueCross BlueShield	Comprehensive	$110.92	$187.41	$251.68	$117.22	$201.88	$274.50
	Advantage	$113.80	$192.27	$258.20	$120.10	$206.73	$281.01

PART-TIME (50% TO 74% FTE) EMPLOYEE RATES*
Please Note: All rates are **monthly**

		Medical Only			Medical and Dental		
Network Option	Plan Option	Single	Two-Party	Family	Single	Two-Party	Family
University Health Care Plus	Comprehensive	$273.83	$462.67	$621.33	$289.58	$498.83	$678.36
	Advantage	$281.01	$474.81	$637.63	$296.76	$510.98	$694.66
BlueCross BlueShield	Comprehensive	$277.31	$468.53	$629.21	$293.06	$504.69	$686.24
	Advantage	$284.49	$480.67	$645.51	$300.24	$516.83	$702.54

***WellU participants receive a discount of $25.00/month from above rates.**