SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2022

Provider Networks

Preferred ValueCare	Find a Medical Provider **www.regence.com** (800) 262-9712 or **healthcare.utah.edu/fad/** (801) 581-2121 (for U Health Providers)	All University of Utah Health facilities and providers, plus over **15,206 Utah providers** and access to **41 of Utah's 52 hospitals** (including Primary Children's Medical Center as an Other Network Provider); **all urgent care centers** in Utah; and nationwide coverage through the BlueCard PPO Network.
Participating (PAR)		All University of Utah Health facilities and providers, plus over **15,435 providers** in Utah and access to **all 52 hospitals** (including Intermountain Healthcare and Primary Children's Medical Center as Other Network Providers); **all urgent care centers** in Utah; and nationwide coverage through the BlueCard Traditional Network.
Huntsman Mental Health Institute	Advantage Plan members find a Mental Health Provider – call the EAP at (801) 587-9319 or (800) 926-9619	Advantage Plan members use the HMHI Network. This network includes the Huntsman Mental Health Institute hospital and all University of Utah Health mental health, substance use disorder treatment, and autism spectrum disorder providers, as well as many other providers within Utah – approximately 660 providers and growing; as well as a panel of providers outside Utah.

Health Plan Design Options

Plan Year Deductibles

	Advantage Plan Option			Consumer Directed Health Plan (CDHP) Option
	University Health Providers	**Other Network Providers**	**Out-of-Network Providers**	**Preferred ValueCare and Out-of-Network Providers**
Medical Coverage Deductibles[1]	$200 per member $400 per family		$500 per member $1,000 per family	Network: $1,500 Single Coverage / $3,000 Two-party or Family Coverage Out-of-Network: $3,000 Single Coverage / $6,000 Two-Party or Family Coverage
Prescription Drug Coverage	$0	$0	$0	
Mental Health and Substance Use Disorder Coverage	$200 per member / $400 per family for Inpatient and Residential Services		$500 per member $1,000 per family for Inpatient and Residential Services	

Plan Year Out-of-Pocket Maximums

	Advantage Plan Option		CDHP Plan Option
	University Health and Other Network Providers	**Out-of-Network Providers**	
Medical	$2,500 per member $5,000 per family	$5,000 per member $10,000 per family	Combined Out-of-Pocket Maximum Network: $5,000 per member / $10,000 per family Out-of-Network: $10,000 per member / $20,000 per family
Prescription Drug	$2,500 per member $5,000 per family	$5,000 per member $10,000 per family	
Mental Health, Substance Use Disorder, and ASD	$2,500 per member $5,000 per family	$5,000 per member $10,000 per family	

Medical Coverage (coinsurance is the amount you pay after any applicable deductible)

	Advantage Plan Option			CDHP Plan Option
	University Health Providers	**Other Network Providers**	**Out-of-Network Providers[2]**	**Preferred ValueCare and Out-of-Network Providers**
Inpatient Hospital	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
Outpatient Hospital or Surgical Center	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
Professional Services	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance

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[1] If you use an out-of-network provider, your deductible will increase to the out-of-network deductible amount. You only need to meet one deductible.

[2] Plan payment for out-of-network providers is based on the amount a network provider would accept for the service; you pay your coinsurance plus any balance of billed charges.

Medical Coverage (coinsurance is the amount you pay after any applicable deductible)

	Advantage Plan Option			CDHP Plan Option
	University Health Providers	**Other Network Providers**	**Out-of-Network Providers**	**Preferred ValueCare and Out-of-Network Providers**
Emergency Department	$200 Copay			30% Coinsurance
Rehabilitation Services - Outpatient	$20 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Ambulance Services	20%			30% Coinsurance
Office Visit *Not required for preventive care visits*	$20 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Virtual Urgent Care	$0 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Urgent Care Visit	$40 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Preventive Services and Screening Procedures	0% Coinsurance	0% Coinsurance	40% Coinsurance	0% Coinsurance *(Network)* 30% Coinsurance *(Out-of-Network)*
Lab/X-Ray	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
Durable Medical Equipment	20% Coinsurance			30% Coinsurance
Rehabilitation Services - Inpatient *Limited to 30 days/Plan Year*	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
Neurodevelopmental Therapy	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
	Applies to children age 18 and under. Physical, Occupational, and Speech Therapy each limited to $5,000/Plan Year. Age and dollar limits do not apply to other covered Speech Therapy Services.			
Fertility Benefits *Lifetime Maximum: $10,000*	10% Coinsurance	30% Coinsurance	40% Coinsurance	30% Coinsurance
Spinal Manipulation *Limited to 20 per Plan Year*	$40 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Hearing / Vision Exams *Limited to one per Plan Year*	$20 Copay	$40 Copay	40% Coinsurance	30% Coinsurance

Prescription Drug Coverage

	Advantage Plan Option				CDHP Plan Option
	University Health Pharmacy		**Other Network Pharmacy**		**All Network Pharmacies**
	Coinsurance	30-Day Maximum	Coinsurance	30-Day Maximum	
Generic	20%	$ 150	25%	$ 250	30% Coinsurance *(after deductible has been met; applied to combined out-of-pocket maximum)*
Preferred Brand	20%	$ 200	25%	$ 250	
Non-Preferred Brand	20%	$ 250	35%	$ 350	
Specialty*	20%	$ 300	35%	$ 500	

The Plan will cover fertility medications up to a lifetime maximum of $3,000.

***Specialty medications** must be purchased through the University's Specialty Pharmacy or through Accredo's National Network for health plan members living outside Utah. Contact the U Specialty Pharmacy at (844) 211-6528.*

Mental Health and Substance Use Disorder Coverage

	Advantage Plan Option *(Administered by Huntsman Mental Health Institute/BHN)*		**CDHP Plan Option** *(Administered by Regence)*
	Huntsman Mental Health Network Providers *(Contact EAP for Referral)*	**Out-of-Network Providers**	**Preferred ValueCare and Out-of-Network Providers**
Employee Assistance Program (EAP)	No cost to enrolled employees, enrolled dependents, and other family members residing in the employee's household		
Inpatient Hospital *Limited to 30 days per Plan Year – Prior Authorization Required*	10% Coinsurance after deductible	35% Coinsurance after deductible	30% Coinsurance

Mental Health and Substance Use Disorder Coverage			
Residential Treatment Facility *Limited to 60 days per Plan Year – Prior Authorization Required*	10% Coinsurance after deductible	35% Coinsurance after deductible	30% Coinsurance
Partial Hospitalization Program or Day Treatment *Limited to 70 days per Plan Year – Prior Authorization Required*	10% Coinsurance	35% Coinsurance	30% Coinsurance
Intensive Outpatient Services *Limited to 35 visits per Plan Year – Prior Authorization Required*	10% Coinsurance	35% Coinsurance	30% Coinsurance
Outpatient Therapy – Individual	$20 Copay	35% Coinsurance	30% Coinsurance
Outpatient Therapy – Group	$5 Copay	35% Coinsurance	30% Coinsurance
Office Visits for Medication Management	$20 Copay	35% Coinsurance	30% Coinsurance
Treatment Resistant Mood Disorder Services – *Prior Authorization Required*	10% Coinsurance	35% Coinsurance	30% Coinsurance
Methadone Maintenance Treatment *Prior Authorization Required*	You pay $33.60 copay per week	Not Covered	30% Coinsurance
Psychological and Neuropsychological Testing *Prior Authorization Required*	$20 Copay	35% Coinsurance	30% Coinsurance
Advantage Plan Members: Contact the EAP at (801) 587-9319 or (800) 926-9619 for assistance, information, prior authorization, and referral to a network provider.			

Autism Spectrum Disorder Coverage			
	Advantage Plan Option ***(Administered by Huntsman Mental Health Institute/BHN)***		**CDHP Plan Option** ***(Administered by Regence)***
	Huntsman Mental Health Network Providers ***(Contact EAP for Referral)***	**Out-of-Network Providers**	**Preferred ValueCare and Out-of-Network Providers**
Diagnostic Testing *Prior Authorization Required*	$20 Copay	35% Coinsurance	30% Coinsurance
Applied Behavior Analysis (ABA) Therapy Services	$5 Copay	35% Coinsurance	30% Coinsurance
Social Skills Group Therapy for Individuals with ASD	$5 Copay	35% Coinsurance	30% Coinsurance
Refer to the Medical Benefits section for coverage of occupational therapy, physical therapy, and speech therapy.			

Dental Coverage

Provider Network	Regence ValueCare Dental Network **www.regence.com** *(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: $2,500 lifetime per member

Dental Services	
Basic Coverage *Exams, X-rays, cleanings, fillings, sealings, periodontics, endodontics*	20% Coinsurance
Prosthodontics *Bridges, Crowns, Dentures*	50% Coinsurance
Orthodontics	50% Coinsurance

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). Proof of legal guardianship is required. Children age 26 or older may only be enrolled or remain enrolled if they are unmarried, dependent on the employee, and either a full-time student or disabled. Contact UHRM at (801) 581-7447 for information and see the Summary Plan Description for eligibility rules.

Coverage of Eligible Dependents: The University will take corrective action against employees for enrolling an individual in the Health Care Plan that they know or should know is ineligible and/or filing 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.

To add a new dependent to your coverage or remove a dependent who has lost eligibility, log into UBenefits and click on the Change Your Benefits tile. You must make the change within 90 days of the date of the event. The University cannot refund overpayments due to IRS Regulations, so please make the change as soon as possible. In order for the dependent to be eligible for COBRA Continuation Coverage, you must submit your change within 60 days from the date of the event.

Primary Children's Medical Center: Primary Children's Medical Center is an Intermountain Healthcare facility and is included as a network provider in both network options. In both network options, Primary Children's Medical Center will be paid as an Other Network Provider and not as a University Health provider. Some University Health Providers work at Primary Children's Medical Center and may be paid as a University Health provider if their services are billed separate from the facility.

RedMed: Employees may visit the RedMed Employee Health Clinic on the ground floor of the Union Building. The clinic cannot provide care to family members. Employees who are injured at work should use RedMed as their first point of care unless the injury is critical or life-threatening or occurs after RedMed Clinic hours, in which case the employee should be taken to the nearest appropriate provider.

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.

Federal Laws Opt Out: The University has elected to opt out of several Federal laws that apply to most health plans, including The Mental Health Parity and Addiction Equity Act. Huntsman Mental Health Institute/Behavioral Health Network assists all health plan members in finding an appropriate network provider and advocating for them to receive the appropriate care. For information and referrals, contact the Employee Assistance Program at (801) 587-9319 or (800) 926-9619.

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 UHRM Solutions Center at (801) 581-7447.

MONTHLY CONTRIBUTION RATES
JULY 1, 2022 THROUGH JUNE 30, 2023

FULL-TIME EMPLOYEE MONTHLY RATES (75% TO 100% FTE)*							
Network Option	Plan Option	Medical Only			Medical and Dental		
		Single	Two-Party	Family	Single	Two-Party	Family
Preferred ValueCare	Advantage	$76.66	$134.16	$202.40	$87.38	$158.70	$241.12
	CDHP	$ -	$ -	$ -	$10.72	$24.54	$38.72
BCBS Participating (PAR)	Advantage	$115.36	$201.88	$304.52	$126.08	$226.42	$343.24

UNIVERSITY DEPARTMENT RATES – Full-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$684.68	$1,197.96	$1,807.14	$704.32	$1,243.08	$1,878.30

PART-TIME EMPLOYEE MONTHLY RATES (50% TO 74% FTE)*							
Network Option	Plan Option	Medical Only			Medical and Dental		
		Single	Two-Party	Family	Single	Two-Party	Family
Preferred ValueCare	Advantage	$419.00	$733.14	$1,105.96	$439.54	$780.24	$1,180.26
	CDHP	$342.34	$598.98	$903.56	$362.88	$646.08	$977.86
BCBS Participating (PAR)	Advantage	$457.70	$800.86	$1,208.08	$478.24	$847.96	$1,282.38

UNIVERSITY DEPARTMENT RATES – Part-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$342.34	$598.98	$903.58	$352.16	$621.54	$939.16

*Complete the requirements to participate in the WellU program to receive a discount of up to $40.00/month from the above rates (or $0 if your rate is less than $40).

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 (summary plan descriptions), which can be found online at www.hr.utah.edu/benefits/spd.php.

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