SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2017

Provider Network Options		
Preferred ValueCare	Find a Provider www.regence.com (800) 262-9712	All University of Utah Health 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 PPO Network.
Participating (PAR)		All University of Utah Health 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 Traditional 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 Providers: $0 Other Providers: $350 per member $700 per family	$1,500 Single Coverage $3,000 Two-party and Family Coverage
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
Plan Year Prescription Drug Maximum Coinsurance	$2,000 per member $4,000 per family	$2,000 per member $4,000 per family	
Plan Year Behavioral Health Maximum Coinsurance	$2,000 per member $4,000 per family	$2,000 per member $4,000 per family	
Employee Voluntary Health Savings Account Contribution Maximum	N/A	N/A	Single: $3,400 Two-Party/Family: $6,750

THE AMOUNT YOU PAY FOR COVERED SERVICES (after any applicable deductible has been met):	Advantage			Comprehensive			CDHP
	University of Utah Health Providers	Other Network Providers	Out-of-Network Providers	University of Utah Health 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%

[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 Providers	Other Network Providers	Out-of-Network Providers	University of Utah Health Providers	Other Network Providers	Out-of-Network Providers	Preferred ValueCare Network Providers and Out-of-Network Providers
Rehabilitation Services - Outpatient	$5 copay	$30 copay	35%	5%	25%	35%	30%
Rehabilitation Services - Inpatient *Limited to 30 days/Plan Year*	0%	20%	35%	5%	25%	35%	30%
Durable Medical Equipment, Orthotic and Prosthetic Devices	0%	20%	35%	5%	25%	35%	30%
Neurodevelopmental Therapy	0%	20%	35%	5%	25%	35%	30%
	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.						
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 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; 30 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)*
			Outpatient services: $25 copay up to 30 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		
			Outpatient services: 50% of allowable charges up to 30 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)*
			Outpatient services: 20% per course of treatment		
		When you do not use the EAP	Inpatient services: 50% after $300 deductible per course of treatment		
			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

Regence ValueCare 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. Disabled dependent children who are age 26 or older may be added during open enrollment. Contact the UHRM Solutions Center at (801) 581-7447 for directions. *See the Summary Plan Description for eligibility rules.*

Coverage for Transgender Services: Effective August 1, 2016, the plan provides coverage for certain transgender services. Providers should contact Regence for prior authorization of services and refer to Regence's medical policy.

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

MONTHLY CONTRIBUTION RATES
JULY 1, 2017 THROUGH JUNE 30, 2018

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	$62.40	$109.20	$164.74	$73.00	$133.50	$203.08
	Comprehensive	$62.40	$109.20	$164.74	$73.00	$133.50	$203.08
	CDHP	$-	$-	$-	$10.60	$24.30	$38.34
BlueCross BlueShield Participating [PAR]	Advantage	$93.90	$164.32	$247.88	$104.50	$188.62	$286.22
	Comprehensive	$93.90	$164.32	$247.88	$104.50	$188.62	$286.22

University Contribution Rates – Full-time Employees – All Options

Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$567.56	$993.22	$1,498.34	$587.00	$1,037.90	$1,568.80

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	$346.18	$605.80	$913.90	$366.50	$652.44	$987.46
	Comprehensive	$346.18	$605.80	$913.90	$366.50	$652.44	$987.46
	CDHP	$283.78	$496.60	$749.16	$304.10	$543.24	$822.72
BlueCross BlueShield Participating [PAR]	Advantage	$377.68	$660.92	$997.04	$398.00	$707.56	$1,070.60
	Comprehensive	$377.68	$660.92	$997.04	$398.00	$707.56	$1,070.60

University Contribution Rates – Part-time Employees – All Options

Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$283.78	$496.62	$749.18	$293.50	$518.96	$784.42

***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.**