### Provider Network Options

**Preferred ValueCare**
- Find a Provider
  - [www.regence.com](http://www.regence.com)
  - (800) 262-9712
  - or [healthcare.utah.edu/fad/](http://healthcare.utah.edu/fad/)
  - 801-581-2121
- 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.

### Health Plan Design Options

#### Plan Year Out-of-Pocket Maximums

<table>
<thead>
<tr>
<th></th>
<th>Advantage Plan Option</th>
<th>Consumer Directed Health Plan (CDHP) Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$2,000 per member / $5,000 per family</td>
<td>Combined Out-of-Pocket Maximum: $5,000 per member $10,000 per family</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>$2,000 per member / $4,000 per family</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health and Chemical Dependency</td>
<td>$2,000 per member / $4,000 per family</td>
<td></td>
</tr>
</tbody>
</table>

#### Plan Year Deductibles

<table>
<thead>
<tr>
<th></th>
<th>Advantage Plan Option</th>
<th>CDHP Plan Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>University Health Providers</td>
<td>Other Network Providers</td>
</tr>
<tr>
<td></td>
<td>$50 per member / $100 per family</td>
<td>$50 per member / $100 per family</td>
</tr>
</tbody>
</table>

#### Medical Coverage (the amount you pay for covered services after any applicable deductible has been met)

<table>
<thead>
<tr>
<th></th>
<th>Advantage Plan Option</th>
<th>CDHP Plan Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>0% Coinsurance / 5% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Outpatient Hospital or Surgical Center</td>
<td>0% Coinsurance / 25% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Professional Services</td>
<td>5% Coinsurance / 25% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$200 Copay</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>20%</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$10 Copay</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Telehealth</td>
<td>$0 Copay</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$10 Copay</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Preventive Services and Screening Procedures</td>
<td>0% Coinsurance / 0% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Lab/X-Ray</td>
<td>5% Coinsurance / 25% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Rehabilitation Services - Outpatient</td>
<td>$10 Copay / $30 Copay</td>
<td>35% Coinsurance</td>
</tr>
<tr>
<td>Rehabilitation Services - Inpatient Limited to 30 days/Plan Year</td>
<td>5% Coinsurance / 25% Coinsurance</td>
<td>35% Coinsurance</td>
</tr>
</tbody>
</table>
### Medical Coverage (Continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Advantage Plan Option</th>
<th>CDHP Plan Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>University Health Providers</td>
<td>Other Network Providers</td>
</tr>
<tr>
<td>Neurodevelopmental Therapy</td>
<td>5% Coinsurance</td>
<td>25% Coinsurance</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation Limited to 20 per Plan Year</td>
<td>$10 Copay</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Hearing / Vision Exams Limited to one per Plan Year</td>
<td>$10 Copay</td>
<td>$30 Copay</td>
</tr>
</tbody>
</table>

### Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>Advantage Plan Option</th>
<th>CDHP Plan Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>University Health Pharmacy</td>
<td>Other Network Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>30-Day Maximum</td>
</tr>
<tr>
<td>Generic</td>
<td>20%</td>
<td>$150.00</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>20%</td>
<td>$150.00</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>20%</td>
<td>$150.00</td>
</tr>
<tr>
<td>Specialty*</td>
<td>20%</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

*Specialty medications* must be purchased through the University’s Specialty Pharmacy or through Accredo’s National Network outside Utah. Contact the U Specialty Pharmacy at (844) 211-6528.

### Mental Health Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>Advantage Option (Administered by HMHI Behavioral Health Network)</th>
<th>CDHP Option (Administered by Regence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Providers (Contact EAP for Referral)</td>
<td>Out-of-Network Providers</td>
</tr>
<tr>
<td>Hospital Admittance Limited to 30 days per Plan Year</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance after $200 deductible per inpatient admission</td>
</tr>
<tr>
<td>Partial Hospitalization Program or Day Treatment Limited to 70 days per Plan Year</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Intensive Outpatient Services Limited to 35 visits per Plan Year</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Outpatient Therapy – Individual Limited to 50 visits per Plan Year</td>
<td>$25 Copay</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Office Visits for Medication Management</td>
<td>$25 Copay</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Outpatient Therapy – Group Limited to 30 visits per Plan Year</td>
<td>$5 Copay</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Treatment Resistant Mood Disorder Services</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Psychological Testing Limited to 3 visits per Plan Year Prior authorization required (contact the EAP)</td>
<td>$25 Copay</td>
<td>50% Coinsurance</td>
</tr>
</tbody>
</table>

Advantage Plan Members: Contact the EAP at (801) 587-9319 or (800) 926-9619 for assistance, information, and referral to a network provider.
### Substance Use Disorder Benefits

<table>
<thead>
<tr>
<th></th>
<th>Advantage Option</th>
<th>CDHP Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Administered by HMHI Behavioral Health Network)</td>
<td>(Administered by Regence)</td>
</tr>
<tr>
<td>Network Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Contact EAP for Referral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Employee Assistance Program (EAP)**: No cost to enrolled employees, enrolled dependents, and other family members residing in the employee’s household.

**Inpatient services**
- Advantage Option: 20% Coinsurance
- Out-of-Network Providers: 50% Coinsurance after $300 deductible per inpatient admission
- CDHP Option: 30% Coinsurance (Day and visit limits do not apply)

**Outpatient services**
- Advantage Option: 20% Coinsurance
- Out-of-Network Providers: 50% Coinsurance

**Methadone Maintenance**
- Advantage Option: $168 Copay Per Week
- Out-of-Network Providers: Not Covered

**Advantage Plan Members**: Contact the EAP at (801) 587-9319 or (800) 926-9619 for assistance, information, and referral to a network provider.

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### 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: $2,000 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). 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.

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**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.

**Change in Dependent Eligibility During the Plan Year**: 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.

**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. HMHI 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.

**Social Security Numbers**: The University is required to identify individuals enrolled in health coverage to the IRS. Please provide social security numbers for all dependents enrolled in the health care plan.
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.

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.

MONTHLY CONTRIBUTION RATES*
JULY 1, 2021 THROUGH JUNE 30, 2022

<table>
<thead>
<tr>
<th>Network Option</th>
<th>Plan Option</th>
<th>Medical Only</th>
<th>Medical and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Single</td>
<td>Two-Party</td>
</tr>
<tr>
<td>Preferred ValueCare</td>
<td>Advantage</td>
<td>$70.70</td>
<td>$123.72</td>
</tr>
<tr>
<td></td>
<td>CDHP</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>BlueCross BlueShield Participating (PAR)</td>
<td>Advantage</td>
<td>$106.40</td>
<td>$186.18</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>UNIVERSITY DEPARTMENT RATES – Full-time Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Only</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>$631.44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART-TIME EMPLOYEE MONTHLY RATES (50% TO 74% FTE)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Only</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>$315.72</td>
</tr>
</tbody>
</table>

*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.

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.

University Human Resource Management
250 East 200 South, Suite 125, Salt Lake City, Utah 84111
Phone: (801) 581-7447 / Email: benefits@utah.edu
Web: www.hr.utah.edu/benefits
UBenefits: https://hr.apps.utah.edu/ubenefits