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

## Provider Networks

| | | |
|---|---|---|
| **Preferred ValueCare** | Find a Medical Provider<br>**www.regence.com**<br>(800) 262-9712<br>or<br>**healthcare.utah.edu/fad/**<br>(801) 581-2121<br>(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**; **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**; **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[1]** | **Other Network Providers** | **Out-of-Network Providers** | **Preferred ValueCare and Out-of-Network Providers** |
| Medical Coverage Deductibles[2] | $200 per member<br>$400 per family | | $500 per member $1,000 per family | Network: $1,500 Single Coverage / $3,000 Two-party or Family Coverage<br>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<br>$5,000 per family | $5,000 per member<br>$10,000 per family | Combined Out-of-Pocket Maximum<br>Network: $5,000 per member / $10,000 per family<br>Out-of-Network: $10,000 per member / $20,000 per family |
| Prescription Drug | $2,500 per member<br>$5,000 per family | $5,000 per member<br>$10,000 per family | |
| Mental Health, Substance Use Disorder, and ASD | $2,500 per member<br>$5,000 per family | $5,000 per member<br>$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[3]** | **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 |

[1] This tier includes Primary Children's Hospital effective 11/1/2022.

[2] 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.

[3] 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)*<br>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<br>*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<br>*Limited to 70 days per Plan Year – Prior Authorization Required* | 10% Coinsurance | 35% Coinsurance | 30% Coinsurance |
| Intensive Outpatient Services<br>*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<br>*Prior Authorization Required* | You pay $33.60 copay per week | Not Covered | 30% Coinsurance |
| Psychological and Neuropsychological Testing<br>*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**<br>***(Administered by Huntsman Mental Health Institute/BHN)*** | | **CDHP Plan Option**<br>***(Administered by Regence)*** |
| | **Huntsman Mental Health Network Providers**<br>***(Contact EAP for Referral)*** | **Out-of-Network Providers** | **Preferred ValueCare and Out-of-Network Providers** |
| Diagnostic Testing<br>*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<br>**www.regence.com** *(search for General Dentistry or Pediatric Dentistry)*<br>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<br>Orthodontics: $2,500 lifetime per member |
| **Dental Services** | |
| Basic Coverage<br>*Exams, X-rays, cleanings, fillings, sealings, periodontics, endodontics* | 20% Coinsurance |
| Prosthodontics<br>*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 Hospital:** Primary Children's Hospital is an Intermountain Healthcare facility and is included as a network provider in both network options. In both network options, Primary Children's Hospital will be paid as an Other Network Provider and not as a University Health provider through October 31, 2022. Effective November 1, 2022, PCH will be covered as a University Health 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.**

**University Human Resource Management**
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