SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2024

Provider Networks

Preferred ValueCare	Find a Medical Provider **www.regence.com** (800) 262-9712 or **healthcare.utah.edu/fad/** (801) 581-2121 (U Health Providers)	All UofU Health and Granger Medical Clinic facilities and providers, plus over **19,500 Utah providers** and access to **41 of Utah's 52 hospitals**; **all urgent care centers** in Utah; and nationwide coverage through the National BlueCard PPO Network.
Participating (PAR)		All UofU Health and Granger Medical Clinic facilities and providers, plus over **20,000 providers** in Utah and access to **all 52 hospitals**; **all urgent care centers** in Utah; and nationwide coverage through the National BlueCard Participating Network.
Huntsman Mental Health Institute (HMHI)	Advantage Plan members find a Mental Health Provider – call the EAP at (801) 587-9319 or (800) 926-9619	**Advantage Plan members use the Huntsman Mental Health Institute (HMHI) Network for mental health providers.** This network includes the HMHI hospital and all UofU Health mental health, substance use disorder treatment, and autism spectrum disorder providers and outpatient clinics, as well as 600+ private mental health practitioners spread across Utah. The HMHI team can also coordinate care with providers outside the state of 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]	$250 per member $500 per family		$500 per member $1,000 per family	Network: $1,600 Single Coverage / $3,200 Two-party or Family Coverage Out-of-Network: $3,200 Single Coverage / $6,400 Two-Party or Family Coverage
Prescription Drug Coverage	$50 per member (Tiers 2-4) / $100 per family (Tiers 2-4)			
Mental Health and Substance Use Disorder Coverage	$250 per member / $500 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 you have paid applicable deductible)

	Advantage Plan Option			CDHP Plan Option
	University Health Providers[1]	**Other Network Providers**	**Out-of-Network Providers[3]**	**Preferred ValueCare and Out-of-Network Providers**
Inpatient Hospital	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance
Outpatient Hospital or Surgical Center	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance
Emergency Department	$200 Copay			30% Coinsurance
Professional Services	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance

[1] This tier includes **Granger Medical Clinic** providers and facilities effective 7/1/2024 and 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 an **out-of-network provider** 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 you have paid 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**
Ambulance Services	20%			30% Coinsurance
Office Visit *Not 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	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance
Durable Medical Equipment	20% Coinsurance			30% Coinsurance
Rehab Services – Outpatient	$20 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Rehab Services – Inpatient *Limited to 30 days/Plan Year*	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance
Neurodevelopmental Therapy	$20 Copay	$40 Copay	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: $13,000*	15% Coinsurance	20% 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 each/Plan Year*	$20 Copay	$40 Copay	40% Coinsurance	30% Coinsurance
Hearing Aids – *Limited to one set every two years for members under age 26*	15% Coinsurance	20% Coinsurance	40% Coinsurance	30% Coinsurance

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	15% Coinsurance after deductible	35% Coinsurance after deductible	30% Coinsurance
Residential Treatment Facility *Limited to 60 days per Plan Year – Prior Authorization Required*	15% Coinsurance after deductible	35% Coinsurance after deductible	30% Coinsurance
Partial Hospitalization Program or Day Treatment – *Prior Authorization Required*	15% Coinsurance	35% Coinsurance	30% Coinsurance
Intensive Outpatient Services *Prior Authorization Required*	15% Coinsurance	35% Coinsurance	30% Coinsurance
Outpatient Therapy – Individual	$20 Copay	35% Coinsurance	30% Coinsurance
Outpatient Therapy – Couple	$20 Copay	35% Coinsurance	30% Coinsurance
Outpatient Therapy – Group	$5 Copay	35% Coinsurance	30% Coinsurance
Office Visits for Medication Mgmt.	$20 Copay	35% Coinsurance	30% Coinsurance
Treatment Resistant Mood Disorder Services – *Prior Authorization Required*	15% Coinsurance	35% Coinsurance	30% Coinsurance
Methadone Maintenance Treatment *Prior Authorization Required*	15% Coinsurance	Not Covered	30% Coinsurance
Psychological and Neuropsychological Testing - *Prior Authorization Required*	$20 Copay	35% Coinsurance	30% Coinsurance
Advantage Plan: Contact the EAP at (801) 587-9319 or (800) 926-9619 for assistance, information, prior authorization, and referral to a network provider.			*CDHP Plan use Regence's Preferred ValueCare providers.*

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.			

Prescription Drug Coverage

To search medications and find their tier, log into your account at **www.Regence.com**, *click "Pharmacy" on the left-hand side, then click "Check Costs and Coverage" on the right-hand side.*	Advantage Plan Option				CDHP Plan Option
	University Health Pharmacy		**Other Network Pharmacy**		**All Network Pharmacies**
	Coinsurance	30-Day Maximum	Coinsurance	30-Day Maximum	
Tier 1 - Meds that provide the highest overall value. Mostly includes Generics but may include some Brand Name Meds	20%	$150	25%	$250	30% Coinsurance *(after deductible has been met; applied to combined out-of-pocket maximum)*
Tier 2 - Meds that provide moderate overall value. Includes Brand Name Meds based on how well they work and/or their cost compared to other meds that treat the same condition	20% after deductible	$200	25% after deductible	$250	
Tier 3 - Meds that provide lower overall value. Includes Brand Name Meds based on how well they work and/or their cost compared to other medications that treat the same condition	40% after deductible	$400	40% after deductible	$400	
Tier 4* - Specialty Meds that provide moderate overall value	20% after deductible	$300	35% after deductible	$500	
Compound Meds	20% after deductible	$250	35% after deductible	$350	
Diabetic Supplies	20%	$150	20%	$150	
Insulin	20%	$28	20%	$28	
The Plan will cover fertility medications – combined with lifetime maximum for fertility services.					
***Specialty medications** must be purchased by members residing in Utah through the University's Specialty Pharmacy. Members living outside the State of Utah must purchase through Accredo's National Network. Contact the U Specialty Pharmacy at (844) 211-6528.*					

Dental Coverage

Regence ValueCare Dental Provider 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	Other Basic Coverage and Prosthodontics: $2,000 per plan year - per member Orthodontics: $2,500 lifetime per member

Dental Services

Basic Dental Cleaning and Exam - *Limited to 2 per plan year*	0% Coinsurance
Other Basic Coverage - *X-rays, fillings, sealings, periodontics, endodontics*	20% Coinsurance
Prosthodontics - *Bridges, Crowns, Dentures*	50% Coinsurance
Orthodontics	50% Coinsurance

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, which can be found online at https://benefits.utah.edu/health-care-and-dental-plans/.

MONTHLY CONTRIBUTION RATES
JULY 1, 2024 THROUGH JUNE 30, 2025

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	$92.26	$161.46	$243.58	$103.18	$186.46	$283.06
	CDHP	$20.00	$35.82	$54.58	$30.92	$60.82	$94.06
BCBS Participating (PAR)	Advantage	$183.88	$321.78	$485.42	$194.80	$346.78	$524.90

UNIVERSITY DEPARTMENT RATES – Full-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$823.96	$1,441.70	$2,174.80	$843.98	$1,487.70	$2,247.34

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	$504.24	$882.30	$1,330.98	$525.18	$930.30	$1,406.72
	CDHP	$431.98	$756.66	$1,141.98	$452.92	$804.66	$1,217.72
BCBS Participating (PAR)	Advantage	$595.86	$1,042.62	$1,572.82	$616.80	$1,090.62	$1,648.56

UNIVERSITY DEPARTMENT RATES – Part-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$411.98	$720.86	$1,087.40	$421.98	$743.86	$1,123.68

*Complete the WellU requirements to receive a discount of up to $40 per month from the above rates (if your rate is less than $40, you pay $0).

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. See the Summary Plan Description for eligibility rules.

Coverage of Dependents: To add a new dependent or remove a dependent who has lost eligibility, log into UBenefits and click on Change Your Benefits. 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.***

The University will take corrective action against employees for enrolling an individual that they know or should know is ineligible and/or for 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.

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