SUMMARY COMPARISON OF MEDICAL AND DENTAL OPTIONS
Effective July 1, 2025

	Advantage Plan Preferred ValueCare Network	Advantage Plan Participating Network	Community Plan Healthy Premier Network	Consumer-Directed Plan Preferred ValueCare Network
Best for:	Lower cost networks along Wasatch Front, nationwide and international	Broad Utah access including IH hospitals; Utah residents seeking provider flexibility	Ideal for those living along Wasatch Front and using U Health Providers	May contribute to a Health Savings Account; nationwide and international coverage
UofU Health, Granger Medical Clinics and Primary Children's Hospital	☑ U Health Extended Network	☑ U Health Extended Network	☑ U Health Extended Network	☑ Covered as network providers at the same coinsurance
Mountainstar, CommonSpirit, Tanner Clinic, Foothill Family, Revere Health, Medallus Medical, Ogden Clinic, Alpine Medical Group and Mountain Land PT	☑ Other Network Providers	☑ Other Network Providers	☑ Other Network Providers	
Intermountain Health Providers and Hospitals as Other Network Providers	⚠ Some providers; hospitals outside SL and Davis Counties	☑ Most providers and all hospitals	⚠ Some providers; hospitals outside SL and Davis Counties	⚠ Some providers; hospitals outside SL and Davis Counties
Nationwide Provider Network	☑ Best	☑ Better	☑ Good	☑ Best
International Provider Network	☑ Best	☑ Good	✗ Emergency Only	☑ Best
Doulas included in Network	✗ Not yet	✗ Not yet	☑ Yes	✗ Not yet
Provider Search	Regence.com	Regence.com	uhealthplan.utah.edu	Regence.com
Deductible – Amount You Pay Before the Plan Pays for Network Providers	$275 Individual / $550 Family	$275 Individual / $550 Family	$275 Individual / $550 Family	⚠ $1,650 Single / $3,300 Two-Party and Family
Copays and Coinsurance with providers in **U Health Extended**	☑ Good: $25 / 15%	☑ Good: $25 / 15%	☑ Best: $20 / 10%	⚠ 30%
Copays and Coinsurance with Other Network Providers	☑ Good: $40 / 20%	☑ Good: $40 / 20%	⚠ No copay - all at 30%	⚠ 30%
Premium Rates	☑ Good: $$	⚠ Highest Rate	☑ Good: $$	☑ Low: $
Health Flexible Spending Account ("FSA")	☑ Eligible	☑ Eligible	☑ Eligible	⚠ Not Eligible with HSA
Health Savings Account ("HSA")	✗ Not Eligible	✗ Not Eligible	✗ Not Eligible	☑ Eligible

All plans cover the same prescription drugs and medical, mental health and substance use disorder services. The differences in the plans are the amounts the plan will pay and the provider networks.

Network Providers: The Advantage and Community plan options include all **University of Utah Health, Granger Medical Clinic and Primary Children's Medical Center** facilities and providers in the preferred network (**"U Health Extended"**). The U Health Extended network may be described as Tier 1 or Category 1 in provider search tools. If you use an out-of-network provider in any plan, the plan's payment will be based on the amount a network provider would accept for the service; you will pay your coinsurance plus any balance of billed charges. Not all covered services will be available through preferred or in-network providers. If a preferred or in-network provider is not available, the service will be processed as an out-of-network expense. Be aware that in-network providers might refer you to providers or labs who are outside the network. When you use an out-of-network provider, services will be processed as out-of-network claims. You should verify that the provider is in-network by calling the number on the back of your ID card.

Plan Year Deductibles

	Advantage Plan			Community Plan			Consumer Directed Health Plan
	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	Preferred ValueCare and Out-of-Network Providers
Medical Deductible[2]	$275/member $550/family		$500/member $1,000/family	$275/member $550/family		$500/member $1,000/family	In Network: $1,650 Single Coverage / $3,300 Two-party or Family Coverage Out-of-Network: $3,200 Single Coverage / $6,400 Two-Party or Family Coverage
Prescription Drug Deductible *Applies to Tiers 2, 3 and 4 only*	$55/member $110/family			$55/member $110/family			
Mental Health / Substance Use Disorder Deductible *Applies to Inpatient and Residential Services only*	$275/member $550/family		$500/member $1,000/family	$275/member $550/family		$500/member $1,000/family	

Plan Year Out-of-Pocket Maximums

	Advantage Plan			Community Plan			Consumer Directed Health Plan
	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	Preferred ValueCare and Out-of-Network Providers
Medical OOP Max	$2,625/member $5,250/family		$5,000/member $10,000/family	$2,625/member $5,250/family		$5,000/member $10,000/family	Combined Out-of-Pocket Maximum In Network: $5,000 per member $10,000 per family Out-of-Network: $10,000 per member $20,000 per family
Prescription Drug OOP Max	$2,625/member $5,250/family		$5,000/member $10,000/family	$2,625/member $5,250/family		$5,000/member $10,000/family	
Mental Health / Substance Use Disorder OOP Max	$2,625/member $5,250/family		$5,000/member $10,000/family	$2,625/member $5,250/family		$5,000/member $10,000/family	

Medical Coverage (coinsurance amounts for covered services are applied after you have paid any applicable deductible)

	Advantage Plan			Community Plan			Consumer Directed Health Plan
	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	Preferred ValueCare and Out-of-Network Providers
Inpatient Hospital	15%	20%	40%	10%	30%	40%	30%
Professional Services	15%	20%	40%	10%	30%	40%	30%
Outpatient Hospital or Surgical Center – *Prior Authorization May be Required*	15%	20%	40%	10%	30%	40%	30%
Emergency Department	$200 Copay			$200 Copay			30%
Ambulance Services	20%			20%			30%

[1] **U Health Extended** includes all U Health providers and facilities, Granger Medical Clinic providers and facilities, and Primary Children's Hospital. In provider search tools, it may be referred to as Tier 1 or Category 1.

[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. You may be required to pay the balance of billed charges.

Medical Coverage, Continued (coinsurance amounts for covered services are applied after you have paid any applicable deductible)							
	Advantage Plan			Community Plan			Consumer Directed Health Plan
	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	U Health Extended[1]	Other Network Providers	Out-of-Network Providers	Preferred ValueCare and Out-of-Network Providers
Office Visit *Not preventive care visits*	$25 Copay	$40 Copay	40%	$20 Copay	30%	40%	30%
Virtual Urgent Care	$0 Copay	$40 Copay	40%	$0 Copay	100%	40%	30%
Preventive Services and Screening Procedures	$0 Copay	$0 Copay	40%	$0 Copay	$0 Copay	40%	In Network: 0% Out-of-Network: 30%
Urgent Care Visit	$40 Copay	$40 Copay	40%	$40 Copay	30%	40%	30%
Lab/X-Ray	15%	20%	40%	10%	30%	40%	30%
Durable Medical Equipment	20%			20%			30%
Rehab Services – Outpatient	$25 Copay	$40 Copay	40%	$20 Copay	30%	40%	30%
Rehab Services – Inpatient *Limited to 30 days/Plan Year*	15%	20%	40%	10%	30%	40%	30%
Neurodevelopmental Therapy	$25 Copay	$40 Copay	40%	$20 Copay	30%	40%	30%
	Physical, Occupational, and Speech Therapy each limited to $5,000/Plan Year. Dollar limits do not apply to other covered Speech Therapy Services.						
Fertility Benefits *Lifetime Maximum: $13,000*	15%	20%	40%	10%	30%	40%	30%
Spinal Manipulation *Limited to 20 per Plan Year*	$40 Copay		40%	$40 Copay		40%	30%
Hearing / Vision Exams *Limited to one each/Plan Year*	$25 Copay	$40 Copay	40%	$20 Copay	30%	40%	30%
Hearing Aids – *Limited to one set every two years*	20%	30%	40%	20%	30%	40%	30%

Mental Health and Substance Use Disorder Coverage (coinsurance amounts for covered services are applied after you have paid any applicable deductible)					
	Advantage Plan *(Administered by Huntsman Mental Health Institute/BHN)*		Community Plan *(Administered by Huntsman Mental Health Institute/BHN)*		Consumer Directed Health Plan *(Administered by Regence)*
	Huntsman Mental Health Network Providers	Out-of-Network Providers	Huntsman Mental Health Network Providers	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				
Residential Treatment Facility – *Limited to 60 days per Plan Year – Prior Authorization Required*	15% after deductible	40%	10% after deductible	40%	30%
Inpatient Hospital	15% after deductible	40%	10% after deductible	40%	30%
Partial Hospitalization Program or Day Treatment – *Prior Authorization Required*	15%	40%	10%	40%	30%
Intensive Outpatient Services – *Prior Authorization Required*	15%	40%	10%	40%	30%

Mental Health and Substance Use Disorder Coverage, Continued (coinsurance amounts for covered services are applied after you have paid any applicable deductible)	Advantage Plan *(Administered by Huntsman Mental Health Institute/BHN)*		Community Plan *(Administered by Huntsman Mental Health Institute/BHN)*		Consumer Directed Health Plan *(Administered by Regence)*
	Huntsman Mental Health Network Providers	Out-of-Network Providers	Huntsman Mental Health Network Providers	Out-of-Network Providers	Preferred ValueCare and Out-of-Network Providers
Outpatient Therapy – Individual or Couple	$20 Copay	40%	$20 Copay	40%	30%
Outpatient Therapy – Group	$5 Copay	40%	$5 Copay	40%	30%
Social Skills Group Therapy	$5 Copay	40%	$5 Copay	40%	30%
Office Visits for Medication Management	$20 Copay	40%	$20 Copay	40%	30%
Psychological and Neuropsychological Testing	$20 Copay	40%	$20 Copay	40%	30%
Applied Behavior Analysis (ABA) Therapy Services	$5 Copay	40%	$5 Copay	40%	30%
Treatment Resistant Mood Disorder Services – *Prior Authorization Required*	15%	40%	10%	40%	30%
Methadone Maintenance – *Prior Authorization Required*	15%	Not Covered	10%	Not Covered	30%

Prescription Drug Coverage					
Search the formulary to see the tier a medication is in – go to www.hr.utah.edu/health-wellness/formulary	Advantage Plan and Community Plan				CDHP Plan Option
	Purchase at a U Health Pharmacy		Purchase at Other Network Pharmacy		All Network Pharmacies
	Coinsurance *	30-Day Maximum	Coinsurance *	30-Day Maximum	
Tier 1 - Provide the highest overall value. Includes most Generics and may include some Brand Name Medications	20%	$150	25%	$250	30% Coinsurance *(after deductible has been met; applied to combined out-of-pocket maximum)*
Tier 2 - Provide moderate overall value. Includes Brand Name and a few generics based on how well they work and/or their cost compared to others that treat the same condition	20% after deductible	$200	25% after deductible	$250	
Tier 3 - Provide lower overall value. Includes Brand Name Medications 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 Medications that provide moderate overall value	20% after deductible	$300	35% after deductible	$500	
Compound Medications	20% after deductible	$250	35% after deductible	$350	
Diabetic Supplies	20%	$150	20%	$150	
Insulin	20%	$28	20%	$28	

**** Minimum $7 per 30-Day Supply*** *– if the cost of the medication is less than $7, you pay that actual amount*

The amount the plan pays for ***fertility medications*** *is applied toward the combined $13,000 lifetime maximum for fertility services*

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 unless eligible and participating in Dental 4 Health*	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, 2025 THROUGH JUNE 30, 2026

FULL-TIME EMPLOYEE MONTHLY RATES (75% TO 100% FTE)*							
Plan	Network	Medical Only			Medical and Dental		
		Single	Two-Party	Family	Single	Two-Party	Family
Advantage Plan	Preferred ValueCare	$97.10	$169.94	$256.36	$109.12	$197.44	$299.80
	BCBS Participating	$193.54	$338.68	$510.90	$205.54	$366.18	$554.34
Community Plan	Healthy Premier	$97.10	$169.94	$256.36	$109.12	$197.44	$299.80
CDHP	Preferred ValueCare	$21.06	$37.70	$57.44	$33.06	$65.20	$100.88

*Complete the WellU requirements to receive a discount of up to $25 per month from the above rates (if your rate is less than $25, you pay $0)

UNIVERSITY DEPARTMENT RATES – Full-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$860.22	$1,505.14	$2,270.50	$882.24	$1,555.74	$2,350.28

PART-TIME EMPLOYEE MONTHLY RATES (50% TO 75% FTE)*							
Plan	Network	Medical Only			Medical and Dental		
		Single	Two-Party	Family	Single	Two-Party	Family
Advantage Plan	Preferred ValueCare	$527.20	$922.50	$1,391.60	$550.24	$975.30	$1,474.94
	BCBS Participating	$623.64	$1,091.24	$1,646.14	$646.66	$1,144.04	$1,729.48
Community Plan	Healthy Premier	$527.20	$922.50	$1,391.60	$550.24	$975.30	$1,474.94
CDHP	Preferred ValueCare	$451.16	$790.26	$1,192.68	$474.18	$843.06	$1,276.02

*Complete the WellU requirements to receive a discount of up to $25 per month from the above rates

UNIVERSITY DEPARTMENT RATES – Part-time Employees					
Medical Only			Medical and Dental		
Single	Two-Party	Family	Single	Two-Party	Family
$430.12	$752.58	$1,135.26	$441.12	$777.88	$1,175.14

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. **Once a dependent loses eligibility for coverage, they cannot remain on the plan unless they elect and pay for COBRA coverage.** Failure to remove an ineligible dependent does not make them eligible for coverage. You must make the change within 30 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 an enrolled family member to be eligible for COBRA Continuation Coverage when they lose eligibility as your dependent, 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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