UNIVERSITY OF UTAH HEALTH HOSPITALS AND CLINICS

Summary of Medical, Dental, Mental Health and Pharmacy Coverage – Effective July 1, 2025 through June 30, 2026

University of Utah Health Hospitals and Clinics Human Resources – Benefits Department 801-581-6500 Email: UUHC-HR-Benefits@hsc.utah.edu

MEDICAL NETWORK PROVIDER OPTIONS		
University of Utah Health Plans Healthy Premier Network	801-213-0274 or 833-443-3440	Includes all University of Utah Health Facilities and providers, plus access to **45 hospitals, 99 urgent care centers and 16,490+ providers across the state of Utah**; and nationwide coverage through Aetna Signature Administrators PPO network.
Regence BlueCross BlueShield Preferred ValueCare Network	800-262-9712	Includes all University of Utah Health facilities and providers, plus access to **41 of Utah's 52 hospitals, all urgent care centers in Utah and 19,600+ ValueCare Providers**; and nationwide coverage through the National BlueCard PPO Network.
UNIVERSITY OF UTAH HEALTH PROVIDERS AND FACILITIES (Available through both the Medical Network Provider options)		
University of Utah Health Provider and Facility Lookup	801-581-2121	These providers and facility options are included in the Healthy Premier and Preferred ValueCare network options above. **University of Utah Health is comprised of 5 hospitals and 12 community health care centers and 2,000 medical group members.**
MENTAL HEALTH NETWORK PROVIDER OPTIONS		
Huntsman Mental Health Institute-Behavioral Health Network	Blomquist Hale Solutions (Employee Assistance Program) 801-587-9319 or 800-926-9619	This network includes the Huntsman Mental Health Institute (HMHI), Mental Health practitioners at the University of Utah Hospital, and its entire network of outpatient clinics, alongside **over 700+ private mental health practitioners and 25+ contracted facilities** spread across Utah's wider community.

Your choice of in-network or out-of-network providers affects your out-of-pocket expenses:

- **In-Network:** An in-network provider is one contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates.
- **Out-of-Network:** These providers do not have a provider discount agreement with the network you select. Payment by the plan will be based on the amount a network provider has agreed to accept for the services. Your out-of-pocket expenses will generally be higher if you use an out- of-network provider. **Choosing an out-of-network provider means you may be billed by the provider for amounts that exceed the amount a network provider has agreed to accept as payment in full.**

MEDICAL PLAN DESIGN (CLICK TO SEE DEFINITION OF TERMS)

Plan Year Deductibles

The annual deductible is the amount you pay out-of- pocket for certain types of care (inpatient and outpatient services) before the plan pays for coverage.
Copays are **not** subject to meeting the deductible.

	In-Network	Out-of-Network
Medical and Mental Health and Substance Use Disorder Combined Deductible	$1,250 per member $2,500 per two-party or family coverage	$2,500 per member $5,000 per two-party or family coverage
Prescription Drug	$0	$0

Plan Year Out-of-Pocket Maximums		
In-network deductible, copay and coinsurance apply toward the medical out-of-pocket maximum.		
	In-Network (Includes deductible)	**Out-of-Network**
Medical, Mental Health and Substance Use Disorder, and Prescription Drug combined OOP Maximum	$4,000 per member $8,000 per two-party or family coverage	No limit

MEDICAL COVERAGE - YOUR COSTS					
	In-Network		**In-Network**		
	University of Utah Health Plans Healthy Premier		**Regence BlueCross BlueShield Preferred ValueCare**		
	U of U Health Providers and Facilities (Category 1*)	**Healthy Premier Network** (Category 2**)	**U of U Health Providers and Facilities** (Category 1*)	**Preferred ValueCare Network** (Category 2**)	**Out-of-Network**
Inpatient Hospital Charges	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Inpatient Professional Services	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Urgent Care	$20 U of U Health clinics	$75 Non-U of U Health clinics	$20 U of U Health clinics	$75 Non-U of U Health clinics	50% coinsurance
Emergency Room	$350 copay				
Ambulance Services	15% coinsurance				
Lab/X-Ray, Outpatient Hospital, Professional Services	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Office Visit	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	50% coinsurance
Maternity Care	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Fertility Benefits Lifetime Maximum $13,000	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Preventive Services and Screening Procedures	No cost to you				50% coinsurance
Durable Medical Equipment, Orthotic and Prosthetic Devices	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Spinal Manipulation (As an office visit) Limited to 20 per plan year	$35 copay for specialist	$55 copay for specialist	$35 copay for specialist	$55 copay for specialist	50% coinsurance
Rehabilitation Services Inpatient: Limited to 60 days per plan year	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Rehabilitation Services Outpatient: Limited to 60 days per plan year	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	50% coinsurance

Neurodevelopmental Therapy Children age 6 and under Speech therapy to age 18. Limited to $5,000 per plan year. Age and dollar limits do not apply to other covered speech therapy services.	$35 copay for specialist	$55 copay for specialist	$35 copay for specialist	$55 copay for specialist	50% coinsurance
*Category 1 – Preferred providers that offer lower copays and coinsurances within the networks. **Category 2 – Participating providers that offer coverage within the networks.					

VISION/HEARING COVERAGE - YOUR COSTS					
	In-Network		**In-Network**		
	University of Utah Health Plans Healthy Premier		**Regence BlueCross BlueShield Preferred ValueCare**		
	U of U Health Providers and Facilities/Moran Eye Centers (Category 1*)	**Healthy Premier Network** (Category 2**)	**U of U Health Providers and Facilities/Moran Eye Centers** (Category 1*)	**Preferred ValueCare Network** (Category 2**)	**Out-of-Network**
Vision Exam - Office Visit To ensure you are not charged for the annual exam, please indicate your visit is an annual exam and you want to see an optometrist. *Contact lens fitting fees apply when contact lenses are required.*	No cost to you for an **annual exam** with optometrist $20 copay optometrist $35 copay for ophthalmologist	$45 for optometrist $55 for ophthalmologist	No cost to you for an **annual exam** with optometrist $20 copay optometrist $35 copay for ophthalmologist	$45 for optometrist $55 for ophthalmologist	50% coinsurance
Eye Surgery	10% coinsurance	25% coinsurance	10% coinsurance	25% coinsurance	50% coinsurance
Hearing Exams Limited to one preventative exam each per plan year	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	$20 copay for primary care $35 copay for specialist	$45 copay for primary care $55 copay for specialist	50% coinsurance
*Category 1 – Preferred providers that offer lower copays and coinsurances within the networks. **Category 2 – Participating providers that offer coverage within the networks.					

MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER COVERAGE - YOUR COSTS

Note: The Mental Health and Substance Use Disorder benefit is solely administered through the Huntsman Mental Health Institute Behavioral Health Network. All treatment must meet medical necessity requirements. Contact a Huntsman Mental Health care coordinator through the Employee Assistance Program (EAP) at 801-587-9319 or 800-926-9619 for an appropriate network provider.

	HMHI Behavioral Health In - Network Providers	Out-of-Network Providers*
Inpatient Hospitalization *Contact EAP for required Prior Authorization*	10% coinsurance	50% coinsurance
Partial Hospitalization Program or Day Treatment *Contact EAP for required Prior Authorization*	10% coinsurance	50% coinsurance
Residential Treatment Facility Limited to 60 days per Plan Year *Contact EAP for required Prior Authorization*	10% coinsurance	50% coinsurance
Intensive Outpatient Services *Contact EAP for required Prior Authorization*	10% coinsurance	50% coinsurance
Outpatient Therapy – Individual	$25 copay	50% coinsurance
Outpatient Therapy – Couples	$25 copay	50% coinsurance
Outpatient Therapy – Group	$5 copay	50% coinsurance
Office Visits for Medication Management	$25 copay	50% coinsurance
Treatment Resistant Mood Disorder Services *Contact EAP for required Prior Authorization*	10% coinsurance	50% coinsurance
Methadone Maintenance - *Prior* *Contact EAP for required Prior Authorization*	10% coinsurance	Not covered
Psychological Testing	$25 copay	50% coinsurance

Contact the EAP at 801-587-9319 or 800-926-9619 for assistance, information, and referral to a network provider.
The out of network benefit will pay 50% of **allowable charges, member responsible for 50% coinsurance and any balance difference.*

AUTISM COVERAGE - YOUR COSTS

	HMHI Behavioral Health In - Network Providers	Out-of-Network Providers
Diagnostic Screening / Diagnostic Testing	$25 copay	Not covered
Applied Behavior Analysis (ABA) Therapy Services	$5 copay	50% coinsurance
Social Skills Group Therapy	$5 copay	Not covered

Pre-authorization of diagnostic screening, diagnostic testing, treatment plans, and ongoing review of goals and progress is required. Coverage under this section may also be available for members with Smith-Magenis Syndrome, Downs Syndrome and Fragile X when medically necessary. Contact the Huntsman Mental Health case management team through the Employee Assistance Program at 801-587-9319 or 800- 926-9619 to obtain a referral to a network provider. Occupational therapy, physical therapy and speech therapy are covered under Medical Benefits (see Neurodevelopmental Therapy and Rehabilitation Services benefits). The member's copay or coinsurance expense for the services listed above do not count toward the member's medical out-of-pocket maximum for the plan year.

PRESCRIPTION DRUG COVERAGE - YOUR COSTS			
University of Utah Health Plans Pharmacy Services 855-856-5690 – available 24 hours, 7 days a week			
Costs are based on a 30-day supply, unless otherwise indicated	**U of U Health provider with U of U Health pharmacy**	**U of U Health pharmacy only**	**In-Network Non-U of U Health Pharmacy**
Tier 1: Preferred Generic	Up to $15 copay	Up to $30 copay	Up to $30 copay
Tier 2: Non-Preferred Generic/Preferred Brand	20% coinsurance ($400 max per 30-day supply)	30% coinsurance ($400 max per 30-day supply)	30% coinsurance ($400 max per 30-day supply)
Tier 3: Non-Preferred Brand	25% coinsurance	35% coinsurance	35% coinsurance
Tier 4: Preferred Specialty	20% coinsurance ($400 max on 30-day supply)	20% coinsurance ($400 max on 30-day supply)	20% coinsurance ($400 max on 30-day supply)
Mail Order and/or 90 supply			
Tier 1: Preferred Generic	2 copays per 90-day supply	2 copays per 90-day supply	2 copays per 90-day supply
Tier 2: Non-Preferred Generic/Preferred Brand	20% coinsurance (up to $600 max per 90-day supply)	30% coinsurance (up to $600 max per 90-day supply)	30% coinsurance (up to $600 max per 90-day supply)
Tier 3: Non-Preferred Brand	25% coinsurance	35% coinsurance	35% coinsurance

DENTAL COVERAGE - YOUR COSTS	
Regence BlueCross BlueShield Expressions Dental ValueCare Network 800-262-9712	
	In-Network
Deductible	None
Maximum Benefits	Basic Coverage and Prosthodontics: $2,000 per plan year per member Orthodontics: $2,500 lifetime per member
Preventive Exams	Annual exams covered at 100%, limited to two oral exams and two cleanings per member per plan year. Complete mouth x-rays are limited to one in a three-year period.
Basic Coverage (fillings, periodontics, endodontics)	20% coinsurance of RBCBS allowed amounts
Major (Bridges, crowns, dentures)	50% coinsurance of RBCBS allowed amounts
Orthodontics	50% coinsurance of RBCBS allowed amounts
All benefits are paid based on Regence allowed amounts.	

Change in Dependent Eligibility during the Plan Year: If one of your dependents loses eligibility (e.g., you divorce or your child turns 26), you must submit an online life event within 30 days of the event to remove the ineligible person from your coverage. Hospitals and Clinics cannot refund overpayments due to IRS regulations; to avoid overpayment go online and submit a life event in a timely manner. **In order for the dependent to be eligible for COBRA Continuation Coverage, you must go online and submit the life event change within 30 days of the date of the event.** To add a new dependent to your coverage, you must submit an online life event within 30 days of the event for the dependent to gain coverage. Hospitals and Clinics will take corrective action against participants 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.