PEHP Health & Benefits

STAR HSA

Summit, Advantage & Preferred

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,500 Double/family plans: $3,000 *One person or a combination can meet the $3,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $2,500 Double plans: $5,000 Family plans: $7,500 *One person or a combination can meet the $7,500 family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations. See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit after deductible	Not applicable
PEHP Value Clinics	**Medical:** 20% after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	20% after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost. $25 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost. $50 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 10 visits per plan year*	20% after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year*	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	50% after deductible	70% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	50% after deductible	70% after deductible

PEHP Health & Benefits

Traditional (Non-HSA)

Summit, Advantage & Preferred

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Does not apply to Out-of-Pocket Maximum*	Single plans: $350 Double/family plans: $350 per person, $700 per family *One person cannot meet more than $350*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the out-of-pocket maximum.*	Single plans: $3,000 Double plans: $3,000 per person, $6,000 per double Family plans: $3,000 per person, $9,000 per family *One person cannot meet more than $3,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations. See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$25 co-pay per visit **IHC:** $35 co-pay per visit for Summit and Preferred networks **University of Utah Medical Group:** $35 co-pay per visit	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay per visit **IHC:** $45 co-pay per visit for Summit and Preferred networks **University of Utah Medical Group:** $45 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit	$35 co-pay per visit
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	$35 co-pay per visit **University of Utah Medical Group:** $45 co-pay per visit	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost. $25 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost. $50 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	$45 co-pay per visit	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	20% of In-Network Rate, minimum $150 co-pay per visit	20% of In-Network Rate, minimum $150 co-pay per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization. See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 10 visits per plan year*	Applicable office co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year*	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services** | *Select services only. See Master Policy for details*	50% after deductible	70% after deductible
Temporomandibular Joint Dysfunction** *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	50% after deductible	70% after deductible

** Does not apply to the out-of-pocket maximum

Important Notice: Consumer Plus is administered by its own Master Policy. The benefits are very different from the Traditional or STAR plans. Find details in the Consumer Plus Master Policy.

You may not select Consumer Plus unless you are currently on The STAR Plan.

If you choose Consumer Plus, you must enroll in an HSA-qualified plan the next enrollment period.

PEHP Health & Benefits

Consumer Plus

(HSA-Qualified)

Summit, Advantage & Preferred

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $6,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $6,050 Double/family plans: $12,100 *One person can only meet $8,150, or a combination can meet the $12,100 double/family maximum*	
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	50% of In-Network Rate after deductible
Vision Screening *One time between ages 3 and 5*	No charge	50% of In-Network Rate after deductible
Pediatric Dental Services** *Routine cleaning, exams, x-rays and fluoride. Two times per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Sealants once every five years. See Master Policy for details.*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Pediatric Vision Services *Lenses only. One time per plan year. Age 3 through the end of the month in which the Member turns 19 years of age.* *Can see Provider of choice*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit after deductible	Not applicable
PEHP Value Clinics	**Medical:** 30% after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	30% after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	30% after deductible	40% after deductible
Surgery and Anesthesia	30% after deductible	40% after deductible
Emergency Room Specialist Visits	30% after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays	30% after deductible	50% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service.* *Inpatient services require preauthorization*	30% after deductible	40% after deductible

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

**Payable only as secondary to a dental plan or if member does not have a separate dental plan.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
30-day Pharmacy *Retail only*	**Preferred generic:** 30% of discounted cost **Preferred brand name:** 30% of discounted cost	Plan pays up to the discounted cost. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	30% of In-Network Rate. No maximum Co-Insurance	Not covered
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	30% of In-Network Rate. No maximum Co-Insurance	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	30% after deductible	50% after deductible
Urgent Care Facility	30% after deductible	50% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	30% after deductible	30% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	30% after deductible	
Diagnostic Tests, Labs, X-rays	30% after deductible	50% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	30% after deductible	50% after deductible
Physical, Occupational and Speech Therapy *Outpatient – Up to 10 combined visits per plan year.*	30% after deductible	50% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	30% after deductible	50% after deductible
Skilled Nursing Facility and Rehabilitation *Non-custodial. Up to 30 days per plan year. Requires preauthorization*	30% after deductible	50% after deductible
Hospice	30% after deductible	50% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	30% after deductible	50% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	30% after deductible, up to $4,000 per adoption	
Allergy Serum	30% after deductible	50% after deductible
Chiropractic care	Not covered	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	30% after deductible Summit Network: Alpine Home Medical	50% after deductible
Medical Supplies *See Master Policy for benefit limits*	30% after deductible	50% after deductible
Home Health/Skilled Nursing *Up to 30 visits per plan year*	30% after deductible	50% after deductible
Injections *Includes allergy injections. See above for allergy serum*	30% after deductible	50% after deductible
Infertility Services	Not covered	Not covered
Sleep Studies and Sleep Equipment	Not covered	Not covered
Temporomandibular Joint Dysfunction	Not covered	Not covered