2017-2018

# **Benefits** Summary

## Utah School Boards Association

Look inside for important information about how to use your PEHP benefits.

PEHP Health & Benefits

**PROUDLY SERVING UTAH PUBLIC EMPLOYEES**

PEHP
Health & Benefits

# Utah School Boards Association

## 2017-18

## USBA Benefits Summary

**UTAH SCHOOL BOARDS ASSOCIATION**
Benefits Summary

Effective September 2017


This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP subscribers who are employed by USBA employers and their eligible dependents. Members of any other PEHP plan should refer to the applicable publications for their coverage.

It is important to familiarize yourself with the information provided in this Benefits Summary and the PEHP Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP. You may also view it at www.pehp.org.

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP. The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at www.pehp.org. All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

The information in this Benefits Summary is distributed on an "as is" basis, without warranty. While every precaution has been taken in the preparation of this Benefits Summary, PEHP shall not incur any liability due to loss, or damage caused or alleged to be caused, directly or indirectly by the information contained in this Benefits Summary.

The information in this Benefits Summary is intended as a service to members of PEHP. While this information may be copied and used for your personal benefit, it is not to be used for commercial gain.

The employers participating with PEHP are not agents of PEHP and do not have the authority to represent or bind PEHP.

7-19-17

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## Introduction



## Medical Benefits



## Wellness and Value-Added Benefits



## Other Benefits

# Welcome to PEHP

**We want to make accessing and understanding your healthcare benefits simple. This Benefits Summary contains important information on how best to use PEHP's comprehensive benefits.**

**Please contact the following PEHP departments or affiliates if you have questions.**

### ON THE WEB

» myPEHP ..... www.pehp.org
myPEHP is your online source for personal health and plan benefit information. You can review your claims history, see a comprehensive list of your coverages, look up in-network providers, check your FLEX$ account, and more.

### CUSTOMER SERVICE

..... 801-366-7555
..... or 800-765-7347

Weekdays from 8 a.m. to 5 p.m.
Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

### PRE-NOTIFICATION/PREAUTHORIZATION

» Inpatient Hospital Pre-notification..... 801-366-7755
..... or 800-753-7754

### MENTAL HEALTH/SUBSTANCE ABUSE PREAUTHORIZATION

» PEHP Customer Service ..... 801-366-7555
..... or 800-765-7347

### PRESCRIPTION DRUG BENEFITS

» PEHP Prescription Customer Service..... 801-366-7551
..... or 888-366-7551

» Express Scripts ..... 800-903-4725
..... www.express-scripts.com

### SPECIALTY PHARMACY

» Accredo..... 800-501-7260

### WELLNESS AND DISEASE MANAGEMENT

» PEHP Healthy Utah..... 801-366-7300
..... or 855-366-7300
..... www.healthyutah.org

» PEHP Waist Aweigh ..... 801-366-7300
..... or 855-366-7300
..... www.pehp.org

» PEHP Integrated Care ..... 801-366-7555
..... or 800-765-7347

### PRENATAL PROGRAM

» PEHP WeeCare ..... 801-366-7400
..... or 855-366-7400
..... www.pehp.org/weecare

### CLAIMS MAILING ADDRESS

**PEHP**
**560 East 200 South**
**Salt Lake City, Utah 84102-2004**

# PEHP Online Tools

## Access Benefits and Claims Online

Access important benefit tools and information by creating an online personal account at www.pehp.org.

- » Receive important messages about your benefits and coverage through our Message Center.
- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.
- » Become a savvy consumer using our Cost & Quality Tools.
- » View and print plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Track your biometric results and access Healthy Utah rebates and resources.
- » Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you'll get an email every time a new one is available.
- » Change your mailing address.

## Find a Provider

Looking for a provider, clinic, or facility that is in-network with your plan? Look no further than **www.pehp.org**. Go online to search for providers by name, specialty, or location.

Some PEHP plans pay benefits for out-of-network providers. However, PEHP doesn't pay for any services from certain providers, regardless if you have an out-of network benefit. Visit **www.pehp.org** to see those providers.

## Access Your Pharmacy Account

Create an account with Express Scripts, PEHP's pharmacy benefit manager, and get customized information that will help you get your medications quickly and at the best price.

Go to **www.express-scripts.com** to create an account. All you need is your PEHP ID card and you're on your way.

You'll be able to:

- » Check prices.
- » Check an order status.
- » Locate a pharmacy.
- » Refill or renew a prescription.
- » Get mail-order instructions.
- » Find detailed information specific to your plan, such as drug coverage, Copayments, and cost-saving alternatives.

# Benefits Changes and Reminders

## Benefit Changes

» **Copper HSA Out-of-Pocket Maximum**
The Out-of-Pocket Maximum on the Copper HSA has changed to $7,000 on family plans.

» **Inpatient Rehabilitation**
Inpatient rehabilitation will be limited to 45 days per plan year.

» **Legal Guardianship Provision**
Employers now have the option to allow children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. In order to continue enrollment, the guardian child must have been enrolled on the employer's coverage prior to being 18 years of age and otherwise have met the qualifications for coverage as a guardian child. PEHP will notify employers on the monthly bill if a guardian child over the age of 19 has enrolled with PEHP.

There is no additional cost to add this provision. However, if a child under guardianship does not qualify as a tax dependent under federal law, the employer may need to impute income to the employee. Employers and employees should consult their tax advisors about any tax consequences.

Make the selection on the benefits selection form to add this provision.

## Reminder

» **PEHP E-Care & Value Clinics**
PEHP recently added two value options – Amwell as an E-Care provider, and access to PEHP Value Clinics.

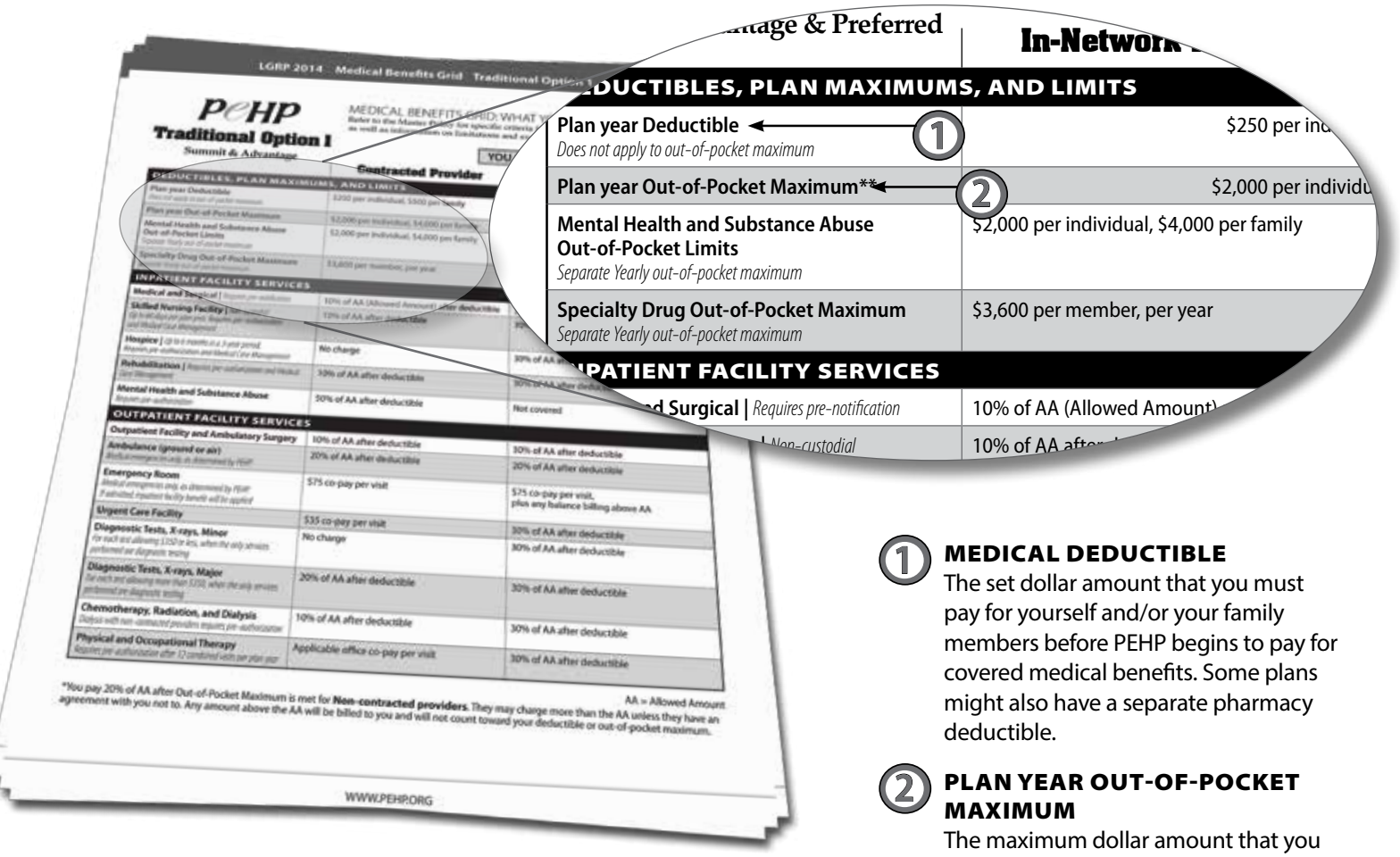
» **Medicare Supplement**
As a reminder, all of PEHP's prescription drug plans are creditable. PEHP's Medicare Part D Prescription Drug Plans are creditable.

» **Pharmacy**
PEHP's Preferred Drug List is modified periodically with changes based on recommendations from PEHP's Pharmacy and Therapeutics Committee.

» **Message Center**
Visit the Message Center at www.pehp.org. This tool allows PEHP to send announcements, messages, and forms that directly relate to our members' needs and concerns.

» **PEHP Treatment Advisor**
This innovative online tool helps you understand your treatment options, based on clinical evidence, patient satisfaction, and your personal preferences.

# Understanding Your Benefits Grid




**CO-PAY**
A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP In-Network Rate.

**IN-NETWORK**
In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay the applicable copayment.

**OUT-OF-NETWORK**
If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP's In-Network Rate.

**IN-NETWORK RATE**
The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the In-Network Rate (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

**1 MEDICAL DEDUCTIBLE**
The set dollar amount that you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

**2 PLAN YEAR OUT-OF-POCKET MAXIMUM**
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for HSA plans).

*For more definitions, please see the Master Policy.*

# Understanding In-Network Providers

It's important to understand the difference between in-network and out-of-network providers and how the In-Network Rate works to avoid unexpected charges.

## In-Network Rate

Doctors and facilities in-network with your network — in-network providers — have agreed not to charge more than PEHP's In-Network Rate for specific services. Your benefits are often described as a percentage of the In-Network Rate. With in-network providers, you pay a predictable amount of the bill: the remaining percentage of the In-Network Rate. For example, if PEHP pays your benefit at 80% of In-Network Rate, your portion of the bill generally won't exceed 20% of the In-Network Rate.

## Balance Billing

It's a different story with out-of-network providers. They may charge more than the In-Network Rate unless they have an agreement with you not to. These doctors and facilities, who aren't a part of your network, have no pricing agreement with PEHP. The portion of the benefit PEHP pays is based on what we would pay an in-network provider. You'll be billed the full amount that the provider charges above the In-Network Rate. This is called "balance billing."

## Negotiate a Price

DON'T GET BALANCE BILLED

Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

Understand that charges to you may be substantial if you see an out-of-network provider. Your plan generally pays a smaller percentage of the In-Network Rate, and you'll also be billed for any amount charged above the In-Network Rate.

The amount you pay for charges above the In-Network Rate won't apply to your Deductible or out-of-pocket maximum.

## Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the comparison on Page 8 or go to www.pehp.org to see which network includes your doctors.

Ask questions before you get medical care. Make sure every person and every facility involved is in-network with your plan.

Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

# PEHP Medical Networks

## PEHP Advantage

The PEHP Advantage network of providers consists of predominantly Intermountain Healthcare (IHC) providers and facilities. It includes 34 participating hospitals and more than 7,500 participating providers.

### PARTICIPATING HOSPITALS

**Beaver County**
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

**Box Elder County**
- Bear River Valley Hospital

**Cache County**
- Logan Regional Hospital

**Carbon County**
- Castleview Hospital

**Davis County**
- Davis Hospital

**Duchesne County**
- Uintah Basin Medical Center

**Garfield County**
- Garfield Memorial Hospital

**Grand County**
- Moab Regional Hospital

**Iron County**
- Cedar City Hospital

**Juab County**
- Central Valley Medical Center

**Kane County**
- Kane County Hospital

**Millard County**
- Delta Community Hospital
- Fillmore Community Hospital

**Salt Lake County**
- Alta View Hospital
- Intermountain Medical Center

**Salt Lake County (cont.)**
- The Orthopedic Specialty Hospital (TOSH)
- LDS Hospital
- Primary Children's Medical Center
- Riverton Hospital

**San Juan County**
- Blue Mountain Hospital
- San Juan Hospital

**Sanpete County**
- Gunnison Valley Hospital
- Sanpete Valley Hospital

**Sevier County**
- Sevier Valley Hospital

**Summit County**
- Park City Medical Center

**Tooele County**
- Mountain West Medical Center

**Uintah County**
- Ashley Valley Medical Center

**Utah County**
- American Fork Hospital
- Orem Community Hospital
- Utah Valley Hospital

**Wasatch County**
- Heber Valley Medical Center

**Washington County**
- Dixie Regional Medical Center

**Weber County**
- McKay-Dee Hospital

## PEHP Preferred

The PEHP Preferred network of providers consists of providers and facilities in both the Advantage and Summit networks. It includes 46 participating hospitals and more than 12,000 participating providers.

## PEHP Summit

The PEHP Summit network of providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 39 participating hospitals and more than 7,500 participating providers.

### PARTICIPATING HOSPITALS

**Beaver County**
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

**Box Elder County**
- Bear River Valley Hospital
- Brigham City Community Hospital

**Cache County**
- Cache Valley Hospital

**Carbon County**
- Castleview Hospital

**Davis County**
- Lakeview Hospital
- Davis Hospital

**Duchesne County**
- Uintah Basin Medical Center

**Garfield County**
- Garfield Memorial Hospital

**Grand County**
- Moab Regional Hospital

**Iron County**
- Cedar City Hospital

**Juab County**
- Central Valley Medical Center

**Kane County**
- Kane County Hospital

**Millard County**
- Delta Community Hospital
- Fillmore Community Hospital

**Salt Lake County**
- Huntsman Cancer Hospital
- Jordan Valley Hospital
- Jordan Valley Hospital - West

**Salt Lake County (cont.)**
- Lone Peak Hospital
- Primary Children's Medical Center
- Primary Children's Hospital - Riverton
- St. Marks Hospital
- Salt Lake Regional Medical Center
- University of Utah Hospital
- University Orthopaedic Center

**San Juan County**
- Blue Mountain Hospital
- San Juan Hospital

**Sanpete County**
- Gunnison Valley Hospital
- Sanpete Valley Hospital

**Sevier County**
- Sevier Valley Hospital

**Summit County**
- Park City Medical Center

**Tooele County**
- Mountain West Medical Center

**Uintah County**
- Ashley Valley Medical Center

**Utah County**
- Mountain View Hospital
- Timpanogos Regional Hospital
- Mountain Point Medical Center

**Wasatch County**
- Heber Valley Medical Center

**Washington County**
- Dixie Regional Medical Center

**Weber County**
- Ogden Regional Medical Center

## Find Participating Providers

Go to www.pehp.org to look up participating providers for each plan.

# PEHP Value Clinics

## MEDICAL

**HSA Plans »** 25% discount on what you would normally pay an in-network provider

**Traditional Plans »** $10 office co-pay

### SALT LAKE CITY

**Health Clinics of Utah**
168 N 1950 W, Ste. 201 | **801-715-3500**

**Midtown Clinic**
230 South 500 East, Suite 510 | **801-320-5660**

**RC Willey Employee Clinic**
2301 South 300 West | **801-464-7900**

**WesTech Wellness Center**
3605 S West Temple | **801-441-1002**

### NORTH SALT LAKE

**Orbit Employee Clinic**
845 Overland St. | **801-951-5888**

**FJM Clinic**
31 N Redwood Rd, Suite 2 | **801-624-1634**

### CLEARFIELD

**Futura Onsite Clinic**
11 H Street | **801-774-3265**

### LAYTON

**Onsite Care at Davis Hospital**
1580 W. Antelope Dr., Suite 110 | **801-807-7699**

### OGDEN

**Health Clinics of Utah**
2540 Washington Blvd., Ste. 122 | **801-626-3670**

**FJM Clinic**
1104 Country Hills Dr., Ste. 110 | **801-624-1633**

### PROVO

**Health Clinics of Utah**
150 E Center St., Ste. 1100 | **801-374-7011**

### OREM

**Blendtec Health and Wellness Clinic**
1206 S 1680 W | **801-225-1281**

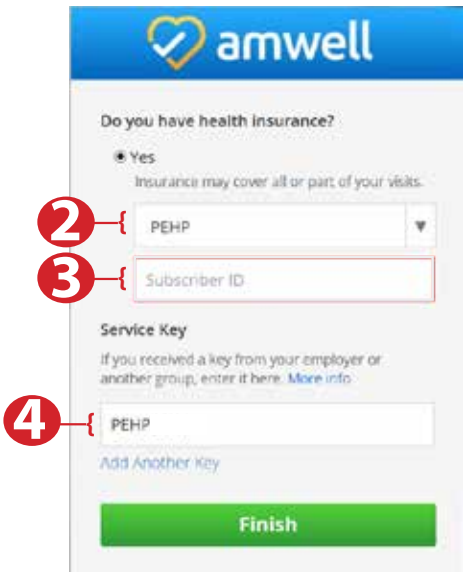
### LEHI

**OnSite Care at Mountain Point Medical**
3000 Triumph Blvd, Ste. 320 | **801-753-4600**

Check with your employer to see which medical and dental plans are available to you. You must be enrolled in an active PEHP medical plan to visit a medical clinic. You must be enrolled in an active PEHP dental plan to visit a dental clinic.

# Amwell On-Demand Doctors

**See a Doctor for $10 »** Amwell doctor visits are available via mobile or web 24 hours a day, every day, and you don't need an appointment. Use Amwell for fevers, ear infections, cold, flu, allergies, migraines, pinkeye, stomach pain, and much more.




## To Get PEHP's Lower Pricing

*Each on-demand doctor consultation costs only a $10 co-pay with PEHP's discount.*

1. Go to www.amwell.com or get the app (available at iTunes and Google Play Store).
2. Choose "PEHP" as your health insurance.
3. Enter your subscriber ID. Find it on your benefits card. Or log in to PEHP for Members at www.pehp.org and go to "See What I'm Enrolled In" in the "my Benefits" menu.
4. Find the service key field and enter "PEHP".

PEHP Health & Benefits

# Gold Plan

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.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS** | | |
| **Plan year Deductible**<br>*Applies to Out-of-Pocket Maximum* | None | $500 per individual, $1,000 per family |
| **Plan year Out-of-Pocket Maximum*** | $3,500 per individual, $7,000 per family | $7,500 per individual, $15,000 per family |
| **INPATIENT FACILITY SERVICES** | | |
| **Medical and Surgical** \| *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details* | 10% of In-Network Rate after $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Skilled Nursing Facility** \| *Non-custodial Up to 60 days per plan year. Requires preauthorization* | 10% of In-Network Rate after $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Hospice** \| *Up to 6 months in a 3-year period. Requires preauthorization* | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Rehabilitation** \| *Up to 45 days per plan year. Requires preauthorization* | 10% of In-Network Rate after $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Mental Health and Substance Abuse**<br>*Requires preauthorization* | 20% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| **Outpatient Facility and Ambulatory Surgery** | 10% of In-Network Rate after $250 Copayment | 40% of In-Network Rate after Deductible and $250 Copayment per visit |
| **Ambulance (ground or air)**<br>*Medical emergencies only, as determined by PEHP* | 10% of In-Network Rate | |
| **Emergency Room**<br>*Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied* | 10% of In-Network Rate after $150 Copayment | 10% of In-Network Rate after $150 Copayment, plus any balance billing above In-Network Rate |
| **Urgent Care Facility** | No charge after $30 Copayment | 40% of In-Network Rate after Deductible |
| **Diagnostic Tests, X-rays** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Chemotherapy, Radiation, and Dialysis** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible. Dialysis requires preauthorization |
| **Physical and Occupational Therapy**<br>*20 visits per plan year.* | No charge after applicable Copayment per visit | 40% of In-Network Rate after Deductible |

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **PROFESSIONAL SERVICES** | | |
| **Inpatient Physician Visits** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Surgery and Anesthesia** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **PEHP e-Care**<br>*Amwell* | **Medical:** $10 co-pay per visit.<br>**Mental Health:** Standard benefits apply | Not applicable |
| **PEHP Value Clinics** | $10 co-pay per visit | Not applicable |
| **Primary Care Office Visits**<br>*Includes office surgeries* | No charge after $20 Copayment per visit | 40% of In-Network Rate after Deductible |
| **Specialist Office Visits**<br>*Includes office surgeries* | No charge after $40 Copayment per visit | 40% of In-Network Rate after Deductible |
| **Emergency Room Specialist Visits** | 10% of In-Network Rate | 10% of In-Network Rate, plus any balance billing above In-Network Rate |
| **University of Utah Medical Group Office Visits**<br>*Preferred plan only. Includes office surgeries* | No charge after $40 Copayment per visit | Not applicable |
| **Diagnostic Tests, X-rays** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Mental Health/Substance Abuse**<br>*No Preauthorization for outpatient services.*<br>*Inpatient services require Preauthorization* | **Inpatient:** 20% of In-Network Rate<br>**Outpatient:** 20% of In-Network Rate, up to 20 visits per plan year | **Inpatient:** 40% of In-Network Rate after Deductible<br>**Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year |
| **PRESCRIPTION DRUGS** | | |
| **30-day Pharmacy**<br>*Retail only* | **Tier 1:** $15 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$30 minimum, $90 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$55 minimum, $200 maximum Copayment | Plan pays up to discounted cost, minus the applicable copayment. Member pays any balance |
| **90-day Pharmacy**<br>*Maintenance only* | **Tier 1:** $25 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$50 minimum, $150 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$100 minimum, $200 maximum Copayment | Not covered |
| **Specialty Medications, retail pharmacy**<br>*Up to 30-day supply* | **Tier A:** 20%. No maximum Copayment<br>**Tier B:** 30%. No maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **Specialty Medications, office/outpatient**<br>*Up to 30-day supply* | **Tier A:** 20% of In-Network Rate. No maximum Copayment<br>**Tier B:** 30% of In-Network Rate. No maximum Copayment | **Tier A:** 40% of In-Network Rate after Deductible. No maximum co-pay<br>**Tier B:** 50% of In-Network Rate after Deductible. No maximum co-pay |
| **Specialty Medications, through specialty vendor Accredo** \| *Up to 30-day supply* | **Tier A:** 20%. $150 maximum Copayment<br>**Tier B:** 30%. $225 maximum Copayment<br>**Tier C:** 20%. No maximum Copayment | Not covered |

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **MISCELLANEOUS SERVICES** | | |
| **Adoption** \| *See Limitations* | No charge, up to $4,000 | |
| **Allergy Serum** | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Chiropractic Care** \| *Up to 20 visits per plan year* | No charge after $40 Copayment per visit | Not covered |
| **Durable Medical Equipment, DME**<br>*Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits* | 20% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Medical Supplies** | 20% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Hearing Aids**<br>*Requires Preauthorization* | 20% of In-Network Rate, up to one pair of hearing aids every three years | Not covered |
| **Home Health/Skilled Nursing**<br>*Up to 60 visits per plan year. Requires Preauthorization* | 10% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Infertility Services*** \| *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum* | 50% of In-Network Rate | 50% of In-Network Rate after Deductible |
| **Injections** \| *Requires Preauthorization if over $750* | **Under $50:** No charge<br>**Over $50:** 20% of In-Network Rate | 40% of In-Network Rate after Deductible |
| **Temporomandibular Joint Dysfunction**<br>*Non-surgical* | Not covered | Not covered |
| **Dental Accident Benefit** | 10% of In-Network Rate. See Limitations | 10% of In-Network Rate plus any balance billing above In-Network Rate. See Limitations |
| **WELLCARE PROGRAM \| ANNUAL ROUTINE CARE** | | |
| **Affordable Care Act Preventive Services** | No charge | Not covered |
| **Routine Vision Exams**<br>*1 visit per year* | No charge after applicable office Copayment per visit | Not covered |
| **Routine Hearing Exams**<br>*1 visit per year* | No charge after applicable office Copayment per visit | Not covered |
| **Diabetes Education**<br>*Must be for the diagnosis of diabetes* | No charge, one occurrence per plan year | No charge plus any balance billing above In-Network Rate, one occurrence per plan year |

PEHP Health & Benefits

# Silver Plan

## 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.

| Summit, Advantage & Preferred | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS** | | |
| **Plan year Deductible**<br>*Applies to Out-of-Pocket Maximum* | $200 per individual, $600 per family | $500 per individual, $1,000 per family |
| **Plan year Out-of-Pocket Maximum*** | $4,500 per individual, $9,200 per family | $8,500 per individual, $17,000 per family |
| **INPATIENT FACILITY SERVICES** | | |
| **Medical and Surgical \|** *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details* | 20% of In-Network Rate after Deductible and $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Skilled Nursing Facility \|** *Non-custodial Up to 60 days per plan year. Requires preauthorization* | 20% of In-Network Rate after Deductible and $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Hospice \|** *Up to 6 months in a 3-year period. Requires preauthorization* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Rehabilitation \|** *Up to 45 days per plan year. Requires preauthorization* | 20% of In-Network Rate after Deductible and $500 Copayment | 40% of In-Network Rate after Deductible and $500 Copayment |
| **Mental Health and Substance Abuse**<br>*Requires preauthorization* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| **Outpatient Facility and Ambulatory Surgery** | 20% of In-Network Rate after Deductible and $250 Copayment | 40% of In-Network Rate after Deductible and $250 Copayment |
| **Ambulance (ground or air)**<br>*Medical emergencies only, as determined by PEHP* | 20% of In-Network Rate after Deductible | |
| **Emergency Room**<br>*Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied* | 20% of In-Network Rate after Deductible and $150 Copayment | 20% of In-Network Rate after Deductible and $150 Copayment, plus any balance billing above In-Network Rate |
| **Urgent Care Facility** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Diagnostic Tests, X-rays** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Chemotherapy, Radiation, and Dialysis** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible. Dialysis requires preauthorization |
| **Physical and Occupational Therapy**<br>*20 visits per plan year.* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **PROFESSIONAL SERVICES** | | |
| **Inpatient Physician Visits** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Surgery and Anesthesia** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **PEHP e-Care**<br>*Amwell* | **Medical:** $10 co-pay per visit.<br>**Mental Health:** Standard benefits apply | Not applicable |
| **PEHP Value Clinics** | $10 co-pay per visit | Not applicable |
| **Primary Care Office Visits**<br>*Includes office surgeries* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Specialist Office Visits**<br>*Includes office surgeries* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Emergency Room Specialist Visits** | 20% of In-Network Rate | 20% of In-Network Rate plus any balance billing above In-Network Rate |
| **Diagnostic Tests, X-rays** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Mental Health/Substance Abuse**<br>*No Preauthorization for outpatient services.*<br>*Inpatient services require Preauthorization* | **Inpatient:** 20% of In-Network Rate after Deductible<br>**Outpatient:** 20% of In-Network Rate after Deductible, up to 20 visits per plan year | **Inpatient:** 40% of In-Network Rate after Deductible<br>**Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year |
| **PRESCRIPTION DRUGS** | | |
| **30-day Pharmacy**<br>*Retail only* | **Tier 1:** $15 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$30 minimum, $90 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$55 minimum, $200 maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **90-day Pharmacy**<br>*Maintenance only* | **Tier 1:** $25 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$50 minimum, $150 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$100 minimum, $200 maximum Copayment | Not covered |
| **Specialty Medications, retail pharmacy**<br>*Up to 30-day supply* | **Tier A:** 20%. No maximum Copayment<br>**Tier B:** 30%. No maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **Specialty Medications, office/outpatient**<br>*Up to 30-day supply* | **Tier A:** 20% of In-Network Rate after Deductible. No maximum Copayment<br>**Tier B:** 30% of In-Network Rate after Deductible. No maximum Copayment | **Tier A:** 40% of In-Network Rate after Deductible. No maximum co-pay<br>**Tier B:** 50% of In-Network Rate after Deductible. No maximum co-pay |
| **Specialty Medications, through specialty vendor Accredo** | *Up to 30-day supply* | **Tier A:** 20%. $150 maximum Copayment<br>**Tier B:** 30%. $225 maximum Copayment<br>**Tier C:** 20%. No maximum Copayment | Not covered |

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **MISCELLANEOUS SERVICES** | | |
| **Adoption** \| *See Limitations* | No charge after Deductible, up to $4,000 (applies to In-network Provider Deductible) | |
| **Allergy Serum** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Chiropractic Care** \| *Up to 20 visits per plan year* | 20% of In-Network Rate after Deductible | Not covered |
| **Durable Medical Equipment, DME** *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Medical Supplies** | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Hearing Aids** *Requires Preauthorization* | 20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years | Not covered |
| **Home Health/Skilled Nursing** *Up to 60 visits per plan year. Requires Preauthorization* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Infertility Services*** \| *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Injections** \| *Requires Preauthorization if over $750* | 20% of In-Network Rate after Deductible | 40% of In-Network Rate after Deductible |
| **Temporomandibular Joint Dysfunction** *Non-surgical* | Not covered | Not covered |
| **Dental Accident Benefit** | 20% of In-Network Rate after Deductible. See Limitations | 20% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations |
| **WELLCARE PROGRAM \| ANNUAL ROUTINE CARE** | | |
| **Affordable Care Act Preventive Services** | No charge | Not covered |
| **Routine Vision Exams** *1 visit per year* | No charge | No charge plus any balance billing above In-Network Rate |
| **Routine Hearing Exams** *1 visit per year* | Not covered | Not covered |
| **Diabetes Education** *Must be for the diagnosis of diabetes* | No charge, one occurrence per plan year | No charge plus any balance billing above In-Network Rate, one occurrence per plan year |

PEHP Health & Benefits

# Bronze Plan

## 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.

| Summit, Advantage & Preferred | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS** | | |
| **Plan year Deductible**<br>*Applies to Out-of-Pocket Maximum* | $750 per individual, $2,250 per family | $2,250 per individual, $4,500 per family |
| **Plan year Out-of-Pocket Maximum*** | $6,350 per individual, $12,700 per family | $10,750 per individual, $21,500 per family |
| **INPATIENT FACILITY SERVICES** | | |
| **Medical and Surgical** \| *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details* | 25% of In-Network Rate after Deductible and $500 Copayment | 45% of In-Network Rate after Deductible and $500 Copayment |
| **Skilled Nursing Facility** \| *Non-custodial Up to 60 days per plan year. Requires preauthorization* | 25% of In-Network Rate after Deductible and $500 Copayment | 45% of In-Network Rate after Deductible and $500 Copayment |
| **Hospice** \| *Up to 6 months in a 3-year period. Requires preauthorization* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Rehabilitation** \| *Up to 45 days per plan year. Requires preauthorization* | 25% of In-Network Rate after Deductible and $500 Copayment | 45% of In-Network Rate after Deductible and $500 Copayment |
| **Mental Health and Substance Abuse**<br>*Requires preauthorization* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| **Outpatient Facility and Ambulatory Surgery** | 25% of In-Network Rate after Deductible and $250 Copayment | 45% of In-Network Rate after Deductible and $250 Copayment |
| **Ambulance (ground or air)**<br>*Medical emergencies only, as determined by PEHP* | 25% of In-Network Rate after Deductible | |
| **Emergency Room**<br>*Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied* | 25% of In-Network Rate after Deductible and $150 Copayment | 25% of In-Network Rate after Deductible and $150 Copayment, plus any balance billing above In-Network Rate |
| **Urgent Care Facility** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Diagnostic Tests, X-rays** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Chemotherapy, Radiation, and Dialysis** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible. Dialysis requires preauthorization |
| **Physical and Occupational Therapy**<br>*20 visits per plan year.* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **PROFESSIONAL SERVICES** | | |
| **Inpatient Physician Visits** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Surgery and Anesthesia** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **PEHP e-Care**<br>*Amwell* | **Medical:** $10 co-pay per visit.<br>**Mental Health:** Standard benefits apply | Not applicable |
| **PEHP Value Clinics** | $10 co-pay per visit | Not applicable |
| **Primary Care Office Visits**<br>*Includes office surgeries* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Specialist Office Visits**<br>*Includes office surgeries* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Emergency Room Specialist Visits** | 25% of In-Network Rate | 25% of In-Network Rate, plus any balance billing above In-Network Rate |
| **Diagnostic Tests, X-rays** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Mental Health/Substance Abuse**<br>*No Preauthorization for outpatient services.*<br>*Inpatient services require Preauthorization* | **Inpatient:** 25% of In-Network Rate after Deductible<br>**Outpatient:** 25% of In-Network Rate after Deductible, up to 20 visits per plan year | **Inpatient:** 45% of In-Network Rate after Deductible<br>**Outpatient:** 45% of In-Network Rate after Deductible, up to 20 visits per plan year |
| **PRESCRIPTION DRUGS** | | |
| **30-day Pharmacy**<br>*Retail only* | **Tier 1:** $15 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$30 minimum, $90 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$55 minimum, $200 maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **90-day Pharmacy**<br>*Maintenance only* | **Tier 1:** $25 Copayment<br>**Tier 2:** 25% of discounted cost.<br>$50 minimum, $150 maximum Copayment<br>**Tier 3:** 50% of discounted cost.<br>$100 minimum, $200 maximum Copayment | Not covered |
| **Specialty Medications, retail pharmacy**<br>*Up to 30-day supply* | **Tier A:** 20%. No maximum Copayment<br>**Tier B:** 30%. No maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **Specialty Medications, office/outpatient**<br>*Up to 30-day supply* | **Tier A:** 20% of In-Network Rate after Deductible. No maximum Copayment<br>**Tier B:** 30% of In-Network Rate after Deductible. No maximum Copayment | **Tier A:** 40% of In-Network Rate after Deductible. No maximum co-pay<br>**Tier B:** 50% of In-Network Rate after Deductible. No maximum co-pay |
| **Specialty Medications, through specialty vendor Accredo** \| *Up to 30-day supply* | **Tier A:** 20%. $150 maximum Copayment<br>**Tier B:** 30%. $225 maximum Copayment<br>**Tier C:** 20%. No maximum Copayment | Not covered |

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **MISCELLANEOUS SERVICES** | | |
| **Adoption** \| *See Limitations* | No charge after Deductible, up to $4,000 (applies to In-network Provider Deductible) | |
| **Allergy Serum** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Chiropractic Care** \| *Up to 20 visits per plan year* | 25% of In-Network Rate after Deductible | Not covered |
| **Durable Medical Equipment, DME**<br>*Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Medical Supplies** | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Hearing Aids**<br>*Requires Preauthorization* | 20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years | Not covered |
| **Home Health/Skilled Nursing**<br>*Up to 60 visits per plan year. Requires Preauthorization* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Infertility Services*** \| *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Injections** \| *Requires Preauthorization if over $750* | 25% of In-Network Rate after Deductible | 45% of In-Network Rate after Deductible |
| **Temporomandibular Joint Dysfunction**<br>*Non-surgical* | Not covered | Not covered |
| **Dental Accident Benefit** | 25% of In-Network Rate after Deductible. See Limitations | 25% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations |
| **WELLCARE PROGRAM \| ANNUAL ROUTINE CARE** | | |
| **Affordable Care Act Preventive Services** | No charge | Not covered |
| **Routine Vision Exams**<br>*1 visit per year* | No charge | No charge plus any balance billing above In-Network Rate |
| **Routine Hearing Exams**<br>*1 visit per year* | Not covered | Not covered |
| **Diabetes Education**<br>*Must be for the diagnosis of diabetes* | No charge, one occurrence per plan year | No charge plus any balance billing above In-Network Rate, one occurrence per plan year |

PEHP Health & Benefits

# Copper 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.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS** | | |
| **Plan year Deductible**<br>*Applies to Out-of-Pocket Maximum* | $1,750 per single, $3,500 per family | |
| **Plan year Out-of-Pocket Maximum** | $3,500 per single, $7,000 per family | |
| **INPATIENT FACILITY SERVICES** | | |
| **Medical and Surgical** \| *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Skilled Nursing Facility** \| *Non-custodial Up to 60 days per plan year. Requires preauthorization* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Hospice** \| *Up to 6 months in a 3-year period. Requires preauthorization* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Rehabilitation** \| *Up to 45 days per plan year. Requires preauthorization* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Mental Health and Substance Abuse**<br>*Requires preauthorization* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| **Outpatient Facility and Ambulatory Surgery** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Ambulance (ground or air)**<br>*Medical emergencies only, as determined by PEHP* | 25% of In-Network Rate after Deductible | |
| **Emergency Room**<br>*Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied* | 25% of In-Network Rate after Deductible | 25% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate |
| **Urgent Care Facility** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Diagnostic Tests, X-rays** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Chemotherapy, Radiation, and Dialysis** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible. Dialysis requires preauthorization |
| **Physical and Occupational Therapy**<br>*20 visits per plan year.* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **PROFESSIONAL SERVICES** | | |
| **Inpatient Physician Visits** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Surgery and Anesthesia** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **PEHP e-Care**<br>*Amwell* | **Medical:** $10 co-pay per visit after Deductible.<br>**Mental Health:** Standard benefits apply after Deductible | Not applicable |
| **PEHP Value Clinics** | **Medical:** 25% of In-Network Rate after Deductible | Not applicable |
| **Primary Care Office Visits**<br>*Includes office surgeries* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Specialist Office Visits**<br>*Includes office surgeries* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Emergency Room Specialist Visits** | 25% of In-Network Rate after Deductible | 25% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate |
| **Diagnostic Tests, X-rays** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Mental Health/Substance Abuse**<br>*No Preauthorization for outpatient services.*<br>*Inpatient services require Preauthorization* | **Inpatient:** 25% of In-Network Rate after Deductible<br>**Outpatient:** 25% of In-Network Rate after Deductible, up to 20 visits per plan year | **Inpatient:** 50% of In-Network Rate after Deductible<br>**Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year |
| **PRESCRIPTION DRUGS** ***All pharmacy benefits for HSA plans are subject to the Deductible*** | | |
| **30-day Pharmacy**<br>*Retail only* | **Tier 1:** 25% of discounted cost<br>**Tier 2:** 25% of discounted cost<br>**Tier 3:** 35% of discounted cost | Plan pays up to discounted cost, minus the applicable Copayment.<br>Member pays any balance |
| **90-day Pharmacy**<br>*Maintenance only* | **Tier 1:** 25% of discounted cost<br>**Tier 2:** 25% of discounted cost<br>**Tier 3:** 35% of discounted cost | Not covered |
| **Specialty Medications, retail pharmacy**<br>*Up to 30-day supply* | **Tier A:** 25%. No maximum Copayment<br>**Tier B:** 30%. No maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment.<br>Member pays any balance |
| **Specialty Medications, office/outpatient**<br>*Up to 30-day supply* | **Tier A:** 25% of In-Network Rate.<br>No maximum Copayment<br>**Tier B:** 30% of In-Network Rate.<br>No maximum Copayment | **Tier A:** 45% of In-Network Rate.<br>No maximum co-pay<br>**Tier B:** 50% of In-Network Rate.<br>No maximum co-pay |
| **Specialty Medications, through specialty vendor Accredo** | *Up to 30-day supply* | **Tier A:** 25%. $150 maximum Copayment<br>**Tier B:** 30%. $225 maximum Copayment<br>**Tier C:** 20%. No maximum Copayment | Not covered |

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **MISCELLANEOUS SERVICES** | | |
| **Adoption** \| *See Limitations* | No charge after Deductible, up to $4,000 | |
| **Allergy Serum** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Chiropractic Care** \| *Up to 20 visits per plan year* | 25% of In-Network Rate after Deductible | Not covered |
| **Durable Medical Equipment, DME** *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Medical Supplies** | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Hearing Aids** *Requires Preauthorization* | 20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years | Not covered |
| **Home Health/Skilled Nursing** *Up to 60 visits per plan year. Requires Preauthorization* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Infertility Services** \| *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Injections** \| *Requires Preauthorization if over $750* | 25% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Temporomandibular Joint Dysfunction** *Non-surgical* | Not covered | Not covered |
| **Dental Accident Benefit** | 25% of In-Network Rate after Deductible. See Limitations | 25% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations |
| **WELLCARE PROGRAM \| ANNUAL ROUTINE CARE** | | |
| **Affordable Care Act Preventive Services** | No charge | Not covered |
| **Routine Vision Exams** *1 visit per year* | No charge | Not covered |
| **Routine Hearing Exams** *1 visit per year* | Not covered | Not covered |
| **Diabetes Education** *Must be for the diagnosis of diabetes* | No charge, one occurrence per plan year | No charge plus any balance billing above In-Network Rate, one occurrence per plan year |

PEHP Health & Benefits

# Core 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.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS** | | |
| **Plan year Deductible**<br>*Applies to Out-of-Pocket Maximum* | $2,100 per single, $4,200 per family | |
| **Plan year Out-of-Pocket Maximum**<br>*Any one individual may not apply more than $6,550 toward the family Out-of-Pocket Maximum* | $6,550 per individual, $13,100 per family | |
| **INPATIENT FACILITY SERVICES** | | |
| **Medical and Surgical \|** *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details* | 50% of In-Network Rate after Deductible | 70% of In-Network Rate after Deductible |
| **Skilled Nursing Facility \|** *Non-custodial Up to 60 days per plan year. Requires preauthorization* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Hospice \|** *Up to 6 months in a 3-year period. Requires preauthorization* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Rehabilitation \|** *Up to 45 days per plan year. Requires preauthorization* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Mental Health and Substance Abuse**<br>*Requires preauthorization* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **OUTPATIENT FACILITY SERVICES** | | |
| **Outpatient Facility and Ambulatory Surgery** | 50% of In-Network Rate after Deductible | 70% of In-Network Rate after Deductible |
| **Ambulance (ground or air)**<br>*Medical emergencies only, as determined by PEHP* | 50% of In-Network Rate after Deductible | |
| **Emergency Room**<br>*Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate |
| **Urgent Care Facility** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Diagnostic Tests, X-rays** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Chemotherapy, Radiation, and Dialysis** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible. Dialysis requires preauthorization |
| **Physical and Occupational Therapy**<br>*20 visits per plan year.* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **PROFESSIONAL SERVICES** | | |
| **Inpatient Physician Visits** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Surgery and Anesthesia** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **PEHP e-Care**<br>*Amwell* | **Medical:** $10 co-pay per visit after Deductible.<br>**Mental Health:** Standard benefits apply after Deductible | Not applicable |
| **PEHP Value Clinics** | **Medical:** 50% of In-Network Rate after Deductible | Not applicable |
| **Primary Care Office Visits**<br>*Includes office surgeries* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Specialist Office Visits**<br>*Includes office surgeries* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Emergency Room Specialist Visits** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate |
| **Diagnostic Tests, X-rays** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Mental Health/Substance Abuse**<br>*No Preauthorization for outpatient services.*<br>*Inpatient services require Preauthorization* | **Inpatient:** 50% of In-Network Rate after Deductible<br>**Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year | **Inpatient:** 50% of In-Network Rate after Deductible<br>**Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year |
| **PRESCRIPTION DRUGS** ***All pharmacy benefits for HSA plans are subject to the Deductible*** | | |
| **30-day Pharmacy**<br>*Retail only* | **Tier 1:** 50% of discounted cost<br>**Tier 2:** 50% of discounted cost<br>**Tier 3:** 60% of discounted cost | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **90-day Pharmacy**<br>*Maintenance only* | **Tier 1:** 50% of discounted cost<br>**Tier 2:** 50% of discounted cost<br>**Tier 3:** 60% of discounted cost | Not covered |
| **Specialty Medications, retail pharmacy**<br>*Up to 30-day supply* | **Tier A:** 50%. No maximum Copayment<br>**Tier B:** 50%. No maximum Copayment | Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance |
| **Specialty Medications, office/outpatient**<br>*Up to 30-day supply* | **Tier A:** 50% of In-Network Rate. No maximum Copayment<br>**Tier B:** 50% of In-Network Rate. No maximum Copayment | **Tier A:** 70% of In-Network Rate. No maximum co-pay<br>**Tier B:** 70% of In-Network Rate. No maximum co-pay |
| **Specialty Medications, through specialty vendor Accredo** | *Up to 30-day supply* | **Tier A:** 50%. $150 maximum Copayment<br>**Tier B:** 50%. $225 maximum Copayment<br>**Tier C:** 20%. No maximum Copayment | Not covered |

| | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **MISCELLANEOUS SERVICES** | | |
| **Adoption** \| *See Limitations* | No charge after Deductible, up to $4,000 | |
| **Allergy Serum** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Chiropractic Care** \| *Up to 20 visits per plan year* | 50% of In-Network Rate after Deductible | Not covered |
| **Durable Medical Equipment, DME** *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Medical Supplies** | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Hearing Aids** *Requires Preauthorization* | 20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years | Not covered |
| **Home Health/Skilled Nursing** *Up to 60 visits per plan year. Requires Preauthorization* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Infertility Services** \| *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Injections** \| *Requires Preauthorization if over $750* | 50% of In-Network Rate after Deductible | 50% of In-Network Rate after Deductible |
| **Temporomandibular Joint Dysfunction** *Non-surgical* | Not covered | Not covered |
| **Dental Accident Benefit** | 50% of In-Network Rate after Deductible. See Limitations | 50% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations |
| **WELLCARE PROGRAM \| ANNUAL ROUTINE CARE** | | |
| **Affordable Care Act Preventive Services** | No charge | Not covered |
| **Routine Vision Exams** *1 visit per year* | No charge | Not covered |
| **Routine Hearing Exams** *1 visit per year* | Not covered | Not covered |
| **Diabetes Education** *Must be for the diagnosis of diabetes* | No charge, one occurrence per plan year | No charge plus any balance billing above In-Network Rate, one occurrence per plan year |

# Wellness and Value-Added Benefits

## PEHP Healthy Utah

PEHP Healthy Utah is an employee health promotion program aimed at enhancing the well-being of members by increasing awareness of health risks and providing support in making health-related lifestyle changes. PEHP Healthy Utah offers a variety of programs, services, cash incentives, and resources to help members get and stay well.

Subscribers and their spouses are eligible to attend one Healthy Utah biometric testing session each plan year free of charge. PEHP Healthy Utah is offered at the discretion of the Employer.

### FOR MORE INFORMATION

**PEHP Healthy Utah**
**801-366-7300 or 855-366-7300**
- **Email: healthyutah@pehp.org**
- **Web: www.pehp.org/healthyutah**

## PEHP WeeCare

PEHP WeeCare is a pregnancy and postpartum program provided to support and educate PEHP members. PEHP WeeCare's goal is to help expectant mothers have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy up to 12 months after delivery.

Participate in PEHP WeeCare and you may qualify for free prenatal vitamins, books and educational resources. Cash incentives are available for enrolling and for postpartum weight loss. While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

### FOR MORE INFORMATION

**PEHP WeeCare**
**P.O. Box 3503**
**Salt Lake City, Utah 84110-3503**
**801-366-7400 | 855-366-7400**
- **E-mail: weecare@pehp.org**
- **Web: www.pehp.org/weecare**

## PEHP Health Coaching

PEHP Health Coaching is a lifestyle behavior change program available to subscribers and spouses with a body mass index (BMI) of 30 or greater. This benefit provides education, support, and rebates to help members engage in improving their health by forming action plans, setting goals, and following up monthly with a health coach.

Rebates are paid based on completing participation requirements rather than on weight loss. Enrolled members will work with a coach for 6-12* months, with the opportunity to receive a $50 rebate at the end of each 6-month interval.

The program is designed to help members achieve a healthy weight by learning how to form and sustain healthy habits. With this approach, members' focus can go beyond weight loss to the greater benefits of lasting health and well-being.

Interested members can enroll by logging on to www.pehp.org, then selecting *My Health › PEHP Wellness › PEHP Health Coaching.*

**Length of enrollment and participation requirements will depend on a member's initial BMI.*

### FOR MORE INFORMATION

**PEHP Health Coaching**
**801-366-7300 | 855-366-7300**
- **E-mail: healthcoaching@pehp.org**
- **Web: www.pehp.org**

If you are unable to meet the medical standards to qualify for the program because it is medically unadvisable or unreasonably difficult due to a medical condition, upon written notification, PEHP shall provide you with a reasonable alternative standard to qualify for the program. The total amount of rewards cannot be more than 30% of the cost of employee-only coverage under the plan.

## PEHP Plus

PEHPplus provides savings of up to 60 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts, so check it out at www.pehp.org/plus.

# Disability Waiver

To the extent allowed under State Law, Subscribers who are approved for long-term disability benefits under either the Public Employees Long-Term Disability Program under Utah Code Annotated Title 49, Chapter 21, or from another Employer-sponsored long-term disability program substantially similar to the Public Employees Long-Term Disability Program, are eligible to continue Coverage with PEHP until the earlier of:

1. The Subscriber no longer receiving long-term disability benefits;
2. The Subscriber's failure to make the required Payment to PEHP each month as set forth below;
3. Group cancellation of medical Coverage with PEHP;
4. The Subscriber or Subscriber's spouse reaching the first of the month in which the Subscriber or Subscriber's spouse attains the age of 65; or
5. The Subscriber or Subscriber's spouse turning 65 will be eligible to continue with a PEHP-sponsored Medicare Supplement plan.
6. For subscribers and their dependents covered under a substantially equivalent long-term disability program, the date the Public Employees Long-Term Disability benefit would end pursuant to Utah Code Annotated Title 49, Chapter 21.

The Subscriber or the Subscriber's spouse who is younger than 65, or any other Dependents covered on the plan younger than 65, will remain eligible for PEHP Coverage until they meet one of the other criteria listed above or no longer meet Dependent eligibility criteria.

The Payment for each disabled Subscriber who qualifies for PEHP Coverage shall be 102% of the regular active Employee Payment. Each disabled Subscriber must pay all or a portion of the monthly PEHP Payment to remain eligible for PEHP benefits as set forth below. The remainder of the monthly Payment, if any, shall be waived by PEHP. The disabled Subscriber shall pay 10% of the monthly PEHP Payment for the first year of eligibility beginning the day after the last day of actual work or last day on Family Medical Leave, 20% for the second year of disability (based off of last day worked), and 30% the third and subsequent years on disability (based on last day worked. The monthly PEHP Payment shall be set by PEHP. Notwithstanding the above percentages, if the disabled Subscriber is more than 30 days in arrears on paying money owed to the Public Employees Long-Term Disability Program, the disabled Subscriber shall pay the full monthly Payment to PEHP.

PEHP, in its sole discretion, shall determine whether another disability benefit is substantially similar to the PEHP LTD Program.