PEHP Health & Benefits

Traditional Option 2

Summit & Advantage Networks

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: $500 Double/family plans: $500 per person, $1,000 per family *One person cannot meet more than $500*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $4,000 Double/family plans: $4,000 per person, $8,000 per family *One person cannot meet more than $4,000*	
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*	$20 co-pay per visit	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$30 co-pay per visit	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$30 co-pay per visit	$30 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	40% after deductible
Mental Health and Substance Abuse *Treatment for Autism requires preauthorization*	**Outpatient:** Applicable Specialist co-pay **Inpatient:** 20% after deductible **Autism:** 20% after deductible	Not covered **Autism:** 40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Retail (30-day supply)		
Tier 1 **Tier 2** **Tier 3**	$15 co-pay $30 co-pay $65 co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
Home Delivery (90-day supply) *Some medications available through retail pharmacy at mail-order co-pay*		
Tier 1 **Tier 2** **Tier 3**	$30 co-pay $60 co-pay $130 co-pay	Not covered

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	$40 co-pay per visit	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, 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
Mental Health & Substance Abuse *Requires Preauthorization*	20% after deductible	Not covered
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	No charge	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization. Residential Treatment benefit: up to 60-day limit applies, no out-of-network coverage*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible	40% after deductible