PEHP Health & Benefits

STAR (HSA-Qualified)

Summit, Advantage & Preferred

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

YOU PAY

	In-Network Provider	Out-of-Network Provider*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible	$1,500 single plan, $3,000 double or family plan	
Plan Year Out-of-Pocket Maximum *Includes amounts applied to Deductibles, Co-Insurance and prescription drugs. Any one individual may not apply more than $7,350 toward the family Out-of-Pocket Maximum*	$2,500 single plan, $5,000 double plan, $7,500 family plan	
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	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *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	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, 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, Minor	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 *Outpatient – up to 20 combined visits per plan year. No Preauthorization required*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible

*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They 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.

	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	**Medical:** $10 co-pay per visit after deductible. **Mental Health:** Standard benefits apply after deductible. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	**Medical:** 20% of In-Network Rate after deductible	Not applicable
Primary Care Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Emergency Room Specialist	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, 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 and Substance Abuse *No preauthorization required for outpatient services. Inpatient services require preauthorization*	**Outpatient:** 20% of In-Network Rate after deductible **Inpatient:** 20% of In-Network Rate after deductible	**Outpatient:** 40% of In-Network Rate after deductible **Inpatient:** 40% of In-Network Rate after deductible
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible*		
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
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 the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate. No maximum co-pay **Tier B:** 30% of In-Network Rate. No maximum co-pay	**Tier A:** 40% of In-Network Rate. **Tier B:** 50% of In-Network Rate.
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C:** 20%. No maximum co-pay	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption or Assisted Reproductive Technology (ART) | *See limitations*	20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Up to 10 visits per plan year*	20% of In-Network Rate after deductible	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and 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 *See the Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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 the Master Policy*	50% of In-Network Rate after deductible	70% 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 *Up to $1,000 lifetime maximum*	50% of In-Network Rate after deductible	70% of In-Network Rate after deductible

PEHP Health & Benefits

Traditional (Non-HSA)

Summit, Advantage & Preferred

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

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *Not included in the Out-of-Pocket Maximum*	$350 per individual, $700 per family	
Plan year Out-of-Pocket Maximum**	$3,000 per individual, $6,000 per double, $9,000 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	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *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	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	20% of In-Network Rate 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, plus any balance billing above In-Network Rate
Urgent Care Facility	$45 co-pay per visit	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 *Outpatient – up to 20 combined visits per plan year. No Preauthorization required*	Applicable office co-pay per visit	40% of In-Network Rate after deductible

*You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They 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.

**Some services on your plan are payable at a reduced benefit of 50% of In-Network Rate or 30% of In-Network Rate. These services do not apply to any out-of-pocket maximum. Deductible may apply. Refer to the Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Visits	Applicable office co-pay per visit	40% of In-Network Rate after deductible
Surgery and Anesthesia *Includes Office-based Surgeries*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	**Medical:** $10 co-pay per visit	Not applicable
Primary Care Office Visits	$25 co-pay per visit **Intermountain or University of Utah Medical Group:** $35 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits	$35 co-pay per visit **Intermountain or University of Utah Medical Group:** $45 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist	$35 co-pay per visit	$35 co-pay per visit, 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 and Substance Abuse *No preauthorization required for outpatient services. Inpatient services require preauthorization*	$35 co-pay per visit **Intermountain or University of Utah Medical Group:** $45 co-pay per visit	**Outpatient:** 40% of In-Network Rate after deductible **Inpatient:** 40% of In-Network Rate after deductible
PRESCRIPTION DRUGS		
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
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 the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 30% of In-Network Rate after deductible. No maximum co-pay	**Tier A:** 40% of In-Network Rate after deductible. **Tier B:** 50% of In-Network Rate after deductible.
Specialty Medications, through specialty vendor Accredo | *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C:** 20%. No maximum co-pay	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption or Assisted Reproductive Technology (ART) | *See limitations*	20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Up to 10 visits per plan year*	Applicable office co-pay per visit	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and 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 *See the Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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 the Master Policy*	50% of In-Network Rate after deductible	70% 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** *Up to $1,000 lifetime maximum*	50% of In-Network Rate after deductible	70% of In-Network Rate after deductible

**Some services on your plan are payable at a reduced benefit of 50% of In-Network Rate or 30% of In-Network Rate. These services do not apply to any out-of-pocket maximum. Deductible may apply. Refer to the Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.