PEHP Health & Benefits

Traditional

Summit

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: $1,000 Double/family plans: $1,000 per person, $2,000 per family *One person cannot meet more than $1,000*	Single plans: $1,500 Double/family plans: $1,500 per person, $3,000 per family *One person cannot meet more than $1,500*
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*	Single plans: $5,500 Double/family plans: $5,500 per person, $11,000 per family *One person cannot meet more than $5,500*
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	Not covered
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Salt Lake County HealthyMe Medical Clinic	$10 co-pay per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$25 co-pay per visit after deductible	30% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay per visit after deductible	30% after deductible
Surgery and Anesthesia	20% after deductible	30% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit after deductible	$35 co-pay per visit after deductible
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	30% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service.* *Inpatient services require preauthorization*	**Outpatient:** $35 co-pay after deductible per visit. **Inpatient:** 20% after deductible	30% 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 / $75 maximum **Tier 3:** 50% of discounted cost, $50 minimum / $100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost, $100 minimum / $200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums accrue separately.

*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%. $150 maximum co-pay after deductible **Tier B:** 20%. $150 maximum co-pay after deductible	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:** 20% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 40% 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 after deductible **Tier B:** 20%. $150 maximum co-pay after deductible **Tier C1:** 10%. No maximum co-pay after deductible **Tier C2:** 20%. No maximum co-pay after deductible **Tier C3:** 30%. No maximum co-pay after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	30% after deductible
Urgent Care Facility	$45 co-pay per visit after deductible	30% 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	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible	30% 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	30% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	30% after deductible
Physical and Occupational Therapy *Outpatient – up to 20 visits per plan year for each therapy type*	$35 co-pay after deductible per visit	30% after deductible
Mental Health & Substance Abuse	20% after deductible	30% 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	30% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	30% after deductible
Hospice	No charge after deductible	30% after deductible
Rehabilitation *Up to 60 days per plan year. Requires preauthorization*	20% after deductible	30% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	20% after deductible	30% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge, plan pays up to $4,000 per adoption	
Allergy Serum	20% after deductible	30% after deductible
Autism Spectrum Disorder	$25 co-pay after deductible	30% after deductible
Bariatric Surgery *Requires Preauthorization. Up to one surgery per lifetime.*	20% after deductible	Not covered
Chiropractic care | *Up to 10 visits per plan year*	$35 co-pay after deductible per visit	$35 co-pay after deductible per visit
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.*	20% after deductible Summit Network: Alpine Home Medical	30% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	30% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge after deductible	30% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge after deductible **Over $50:** 20% after deductible	30% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	50% after deductible	50% after deductible
Temporomandibular Joint Dysfunction** *Non-surgical. Up to $1,000 lifetime maximum*	50% after deductible	50% after deductible

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