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.

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *Applies to out-of-pocket maximum*	$500 per individual, $1,000 per family	$1,000 per individual, $2,000 per family
Plan year Out-of-Pocket Maximum**	$3,500 per individual, $7,000 per family	$5,000 per individual, $10,000 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	30% 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	30% of In-Network Rate after deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	No charge after deductible	30% of In-Network Rate after deductible
Rehabilitation | *Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	$150 co-pay per visit after deductible	$150 co-pay per visit after deductible plus any balance billing above In-Network Rate
Urgent Care Facility	$45 co-pay per visit after deductible	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *Outpatient – up to 20 visits per plan year for each therapy type. No Preauthorization required*	$35 co-pay per visit after deductible	30% of In-Network Rate after deductible

In-network and out-of-network Deductibles accrue separately.

In-network and out-of-network 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.

**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 Office Visits	Applicable office co-pay after deductible	30% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Salt Lake County HealthyMe Medical Clinic	$10 co-pay per visit	Not applicable
Primary Care Office Visits and Office Surgeries	$25 co-pay per visit after deductible	30% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	$35 co-pay per visit after deductible	30% of In-Network Rate after deductible
Emergency Room Specialist Visits	$35 co-pay per visit after deductible	$35 co-pay per visit after deductible plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	No charge after deductible	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	**Outpatient:** $35 co-pay per visit after deductible. **Inpatient:** 20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost after deductible, $25 minimum / $75 maximum **Tier 3:** 50% of discounted cost after deductible, $50 minimum / $100 maximum	Plan pays up to the discounted cost after deductible, 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 after deductible, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost after deductible, $100 minimum / $200 maximum	Not covered
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 the discounted cost after deductible, 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:** 20% of In-Network Rate after deductible. No maximum co-pay	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 40% 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 co-pay after deductible **Tier B:** 20%. $150 maximum co-pay after deductible **Tier C:** 20%. $150 maximum co-pay after deductible	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge, plan pays up to $4,000 per adoption	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	Not covered
Allergy Serum	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Autism Spectrum Disorder *Up to 150 combined visits per plan year for all therapy types*	Regular medical benefits apply. **Ages 0-9:** Plan pays up to $36,000 per plan year. **Ages 10-18:** Plan pays up to $15,000 per plan year	Not covered
Chiropractic Care | *Up to 10 visits per plan year*	$35 co-pay per visit after deductible	$35 co-pay per visit after deductible plus any balance billing above In-Network Rate
Missing Teeth for Dental Accident or Certain Medical Conditions *Three or more missing teeth at a time, and per lifetime. Requires preauthorization. Dental benefits may apply*	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, certain DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Medical Supplies *See Master Policy for benefit limits*	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	No charge after deductible	30% of In-Network Rate after deductible
Infertility Services *Select services only. See Master Policy for details*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections	**Under $50:** No charge after deductible **Over $50:** 20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction *Up to $1,000 Lifetime Maximum*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible