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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Medical Benefits

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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.

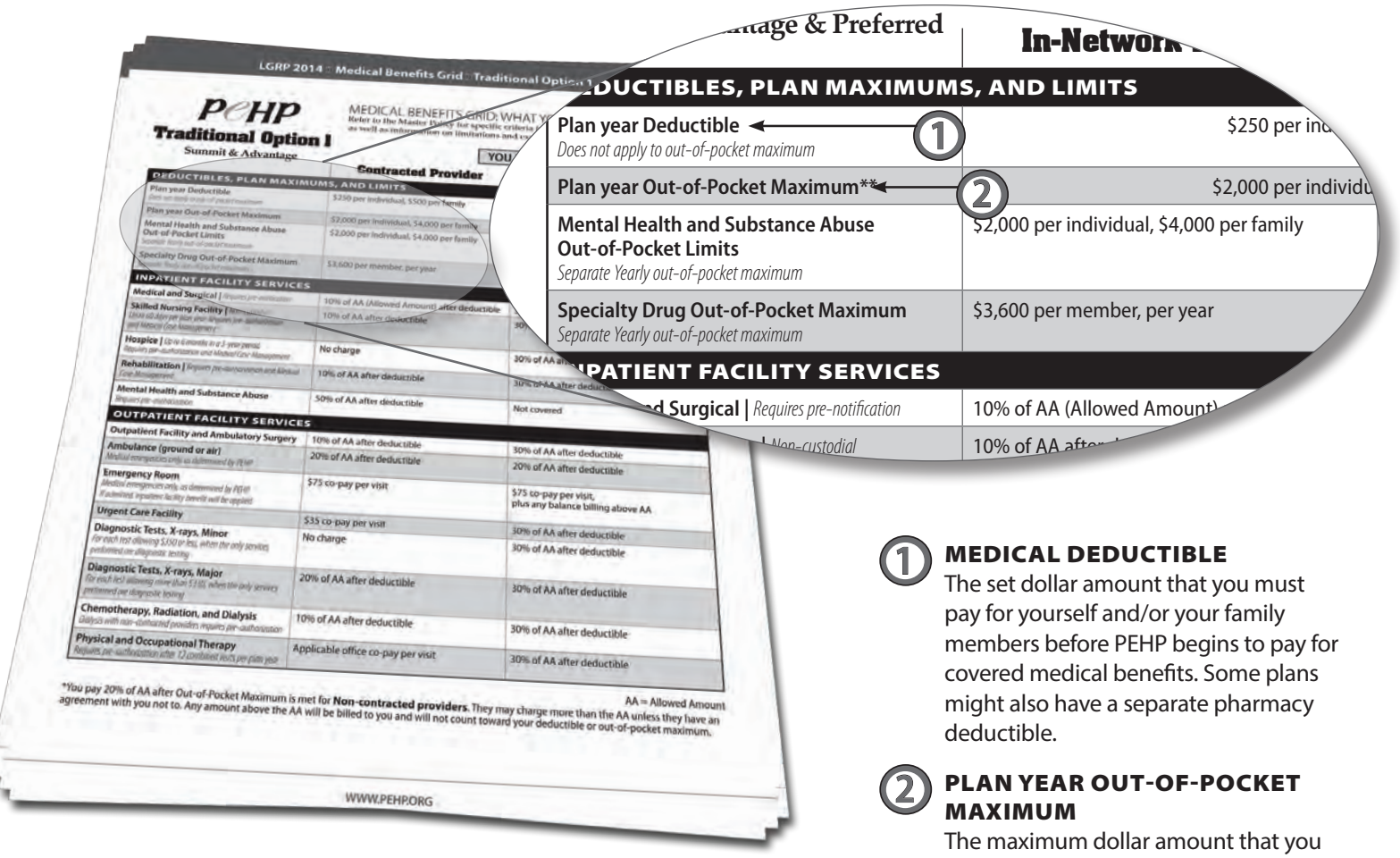
» **Medicare Supplement**
As a reminder, all of PEHP's prescription drug plans are creditable. PEHP's Medicare Part D Prescription Drug Plans are creditable.

» **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



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).

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.

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**

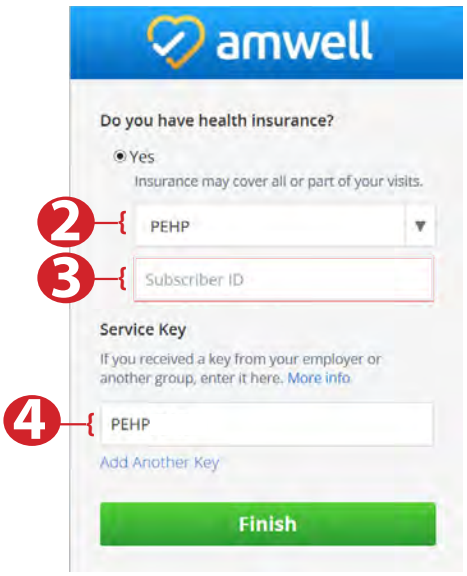
LEHI

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 *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 *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) *Medical emergencies only, as determined by PEHP*	10% of In-Network Rate	
Emergency Room *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 *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 *Amwell*	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits *Includes office surgeries*	No charge after $20 Copayment per visit	40% of In-Network Rate after Deductible
Specialist Office Visits *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 *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 *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 20% of In-Network Rate **Outpatient:** 20% of In-Network Rate, up to 20 visits per plan year	**Inpatient:** 40% of In-Network Rate after Deductible **Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable copayment. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum Copayment **Tier B:** 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate. No maximum Copayment **Tier B:** 30% of In-Network Rate. No maximum Copayment	**Tier A:** 40% of In-Network Rate after Deductible. No maximum co-pay **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 **Tier B:** 30%. $225 maximum Copayment **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 *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 *Requires Preauthorization*	20% of In-Network Rate, 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*	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 **Over $50:** 20% of In-Network Rate	40% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *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 *1 visit per year*	No charge after applicable office Copayment per visit	Not covered
Routine Hearing Exams *1 visit per year*	No charge after applicable office Copayment per visit	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

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 *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 *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) *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*	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 *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 *Amwell*	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits *Includes office surgeries*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Specialist Office Visits *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 *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 20% of In-Network Rate after Deductible **Outpatient:** 20% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 40% of In-Network Rate after Deductible **Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum Copayment **Tier B:** 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after Deductible. No maximum Copayment **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 **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 **Tier B:** 30%. $225 maximum Copayment **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

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 *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 *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) *Medical emergencies only, as determined by PEHP*	25% of In-Network Rate after Deductible	
Emergency Room *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 *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 *Amwell*	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits *Includes office surgeries*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Specialist Office Visits *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 *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 25% of In-Network Rate after Deductible **Outpatient:** 25% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 45% of In-Network Rate after Deductible **Outpatient:** 45% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum Copayment **Tier B:** 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after Deductible. No maximum Copayment **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 **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 **Tier B:** 30%. $225 maximum Copayment **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 *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 *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	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 *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	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

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 *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 *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) *Medical emergencies only, as determined by PEHP*	25% of In-Network Rate after Deductible	
Emergency Room *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 *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 *Amwell*	**Medical:** $10 co-pay per visit after Deductible. **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 *Includes office surgeries*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialist Office Visits *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 *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 25% of In-Network Rate after Deductible **Outpatient:** 25% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 50% of In-Network Rate after Deductible **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 *Retail only*	**Tier 1:** 25% of discounted cost **Tier 2:** 25% of discounted cost **Tier 3:** 35% of discounted cost	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** 25% of discounted cost **Tier 2:** 25% of discounted cost **Tier 3:** 35% of discounted cost	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 25%. No maximum Copayment **Tier B:** 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 25% of In-Network Rate. No maximum Copayment **Tier B:** 30% of In-Network Rate. No maximum Copayment	**Tier A:** 45% of In-Network Rate. No maximum co-pay **Tier B:** 50% of In-Network Rate. No maximum co-pay
Specialty Medications, through specialty vendor Accredo	*Up to 30-day supply*	**Tier A:** 25%. $150 maximum Copayment **Tier B:** 30%. $225 maximum Copayment **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 *Applies to Out-of-Pocket Maximum*	$2,100 per single, $4,200 per family	
Plan year Out-of-Pocket Maximum *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 *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) *Medical emergencies only, as determined by PEHP*	50% of In-Network Rate after Deductible	
Emergency Room *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 *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 *Amwell*	**Medical:** $10 co-pay per visit after Deductible. **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 *Includes office surgeries*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialist Office Visits *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 *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 50% of In-Network Rate after Deductible **Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 50% of In-Network Rate after Deductible **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 *Retail only*	**Tier 1:** 50% of discounted cost **Tier 2:** 50% of discounted cost **Tier 3:** 60% of discounted cost	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** 50% of discounted cost **Tier 2:** 50% of discounted cost **Tier 3:** 60% of discounted cost	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 50%. No maximum Copayment **Tier B:** 50%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 50% of In-Network Rate. No maximum Copayment **Tier B:** 50% of In-Network Rate. No maximum Copayment	**Tier A:** 70% of In-Network Rate. No maximum co-pay **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 **Tier B:** 50%. $225 maximum Copayment **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.