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.

Important Notice: Utah Basic Plus is administered by its own Master Policy. The benefits are very different from the Traditional or STAR plans. Find details in the Utah Basic Plus Master Policy.

You may not select Utah Basic Plus unless you are currently on The STAR Plan.

If you choose Utah Basic Plus, you must enroll in an HSA-qualified plan the next enrollment period.

PEHP Health & Benefits

Utah Basic Plus

(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		
Medical Deductible	$3,000 single plan, $6,000 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*	$6,050 single plan, $12,100 double or 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*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Skilled Nursing Facility and Rehabilitation *Non-custodial. Up to 30 combined days per plan year. Requires preauthorization*	30% 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*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	30% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	30% of In-Network Rate after deductible	30% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Urgent Care Facility	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Diagnostic Tests, X-rays	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible. Dialysis requires preauthorization
Chemotherapy, Radiation, and Dialysis	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Physical, Occupational, and Speech Therapy *Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.*	30% of In-Network Rate after deductible	50% 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	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Emergency Room Physician Visits	30% of In-Network Rate after deductible	30% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Surgery and Anesthesia	30% of In-Network Rate after deductible	50% 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:** 30% of In-Network Rate after deductible	Not applicable
Primary Care Office Visits	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Specialist Office Visits	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Diagnostic Tests, X-rays	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Mental Health/Substance Abuse *No Preauthorization required for outpatient service. Inpatient services require Preauthorization*	30% of In-Network Rate after deductible	50% 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*	**Preferred generic:** 30% of discounted cost **Preferred brand name:** 30% of discounted cost	Plan pays up to the discounted cost. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	30% of In-Network Rate. No maximum Co-Insurance	Not covered
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	30% of In-Network Rate. No maximum Co-Insurance	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	30% after deductible, up to $4,000 per adoption	
Allergy Serum	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Chiropractic Care	Not covered	Not covered
Surgery and Anesthesia	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Durable Medical Equipment, DME *Except for oxygen, 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*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Medical Supplies	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Home Health/Skilled Nursing *Up to 30 visits per plan year. Requires Preauthorization*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Infertility Services	Not covered	Not covered
Injections *Requires Preauthorization if over $750*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction	Not covered	Not covered
Sleep Studies and Sleep Equipment	Not covered	Not covered
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	50% of In-Network Rate after deductible
Vision Screening *One time between ages 3 and 5*	No charge	50% of In-Network Rate after deductible
Pediatric Dental Services** *Routine cleaning, exams, x-rays and fluoride. Two times per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Sealants once every five years. See Master Policy for details.*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Pediatric Vision Services *Lenses only. One time per plan year. Age 3 through the end of the month in which the Member turns 19 years of age.* *Can see Provider of choice*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible

**Payable only as secondary to a dental plan or if member does not have a separate dental plan.