

Traditional (Non-HSA)

SUMMIT CARE

ADVANTAGE CARE

PREFERRED CARE

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions. * Services received by a non-contracted provider will be paid at a percentage of PEHP's Allowed Amount (AA). You will be responsible for your assigned coinsurance and deductible (if applicable). You will also be responsible for any amounts billed by a non-contracted provider in excess of PEHP's Allowed Amount. There is no Out-of-Pocket Maximum for services received from a non-contracted provider.

YOU PAY

Contracted Provider

Non-Contracted Provider

You may be balance billed. See Page 9 for explanation

DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible <i>In and Out of Network Deductibles are combined</i>	\$250 per individual, \$500 per family	Same as using a contracted provider *See Above for Additional Information **See Below for Additional Information
Pharmacy Deductible	\$100 per individual, \$200 per family	Not applicable
Plan year Out-of-Pocket Maximum	\$2,500 per individual \$5,000 per double \$7,500 per family	No Out-of-Pocket Maximum *See Above for Additional Information **See Below for Additional Information
Pharmacy Out-of-Pocket Maximum <i>Does not apply to non-preferred drugs</i>	\$3,000 per individual	Not applicable
Specialty Drug Out-of-Pocket Maximum, office/outpatient <i>Separate yearly out-of-pocket maximum</i>	\$3,600 per individual	No Out-of-Pocket Maximum
Maximum Lifetime Benefit	None	None
Pre-existing Condition Waiting Period <i>Does not apply to any individuals up to age 19</i>	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage
**Applicable deductibles and coinsurance for services provided by a non-contracted provider will apply to your in-network plan year deductible and Out-of-Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, coinsurance amounts for non-contracted providers will still apply.		
INPATIENT FACILITY SERVICES		
Medical and Surgical <i>Requires pre-notification</i>	20% of AA after deductible	40% of AA after deductible
Skilled Nursing Facility <i>Non-custodial Up to 60 days per plan year. Requires pre-authorization through Medical Case Management</i>	20% of AA after deductible	40% of AA after deductible
Hospice <i>Up to 6 months in a 3-year period. Requires pre-authorization through Medical Case Management</i>	20% of AA after deductible	40% of AA after deductible
Rehabilitation <i>Requires pre-authorization through Medical Case Management</i>	20% of AA after deductible	40% of AA after deductible
Mental Health <i>Requires pre-authorization</i>	20% of AA after deductible	40% of AA after deductible
Substance Abuse <i>Requires pre-authorization</i>	20% of AA after deductible	40% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider <i>You may be balance billed. See Page 9 for explanation</i>
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of AA after deductible	40% of AA after deductible
Ambulance (ground or air) <i>Medical emergencies only, as determined by PEHP</i>	20% of AA after deductible	20% of AA after deductible
Emergency Room <i>Medical emergencies only, as determined by PEHP</i>	20% of AA minimum \$150 copayment per visit	20% of AA minimum \$150 copayment per visit
Urgent Care Facility	\$45 copayment per visit Preferred Care only: University of Utah Medical Group Urgent Care Facility: \$50 copayment per visit	40% of AA after deductible
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less</i>	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350</i>	20% of AA after deductible	40% of AA after deductible
Chemotherapy, Radiation, and Dialysis	20% of AA after deductible	40% of AA after deductible <i>Dialysis with non-contracted providers requires pre-authorization</i>
Physical and Occupational Therapy <i>Requires pre-authorization after 12 visits</i>	Applicable office copayment per visit	40% of AA after deductible
PROFESSIONAL SERVICES		
Inpatient Physician Visits	Applicable office copayment per visit	40% of AA after deductible
Surgery and Anesthesia	20% of AA after deductible	40% of AA after deductible
Primary Care Office Visits and Office Surgeries	\$25 copayment per visit Preferred Care only: University of Utah Medical Group Primary Care Office Visits: \$50 copayment per visit	40% of AA after deductible
Specialist Office Visits and Office Surgeries,	\$35 copayment per visit Preferred Care only: University of Utah Medical Group Specialist Office Visit: \$50 copayment per visit	40% of AA after deductible
Emergency Room Specialist	\$35 copayment per visit	\$35 copayment per visit
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less</i>	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350</i>	20% of AA after deductible	40% of AA after deductible
Mental Health and Substance Abuse <i>No pre-authorization required for outpatient services. Inpatient services require pre-authorization</i>	Outpatient: \$35 copayment per visit Inpatient: 20% of AA after deductible	Outpatient: 40% of AA after deductible Inpatient: 40% of AA after deductible

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Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider <i>You may be balance billed. See Page 9 for explanation</i>
PRESCRIPTION DRUGS		
Retail Pharmacy <i>Up to 30-day supply</i>	Preferred generic: \$10 copayment after deductible Preferred brand name: 25% of discounted cost after deductible. \$25 minimum, no maximum copayment Non-preferred: 50% of discounted cost after deductible. \$50 minimum, no maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment. Member pays any balance
Mail-Order <i>90-day supply</i>	Preferred generic: \$20 copayment after deductible Preferred brand name: 25% of discounted cost after deductible. \$50 minimum, no maximum copayment Non-preferred: 50% of discounted cost after deductible. \$100 minimum, no maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment. Member pays any balance
Specialty Medications, retail pharmacy <i>Up to 30-day supply</i>	Tier A: 20% of AA after deductible. No maximum copayment Tier B: 30% of AA after deductible. No maximum copayment	Plan pays up to the discounted cost, minus the preferred copayment. Member pays any balance
Specialty Medications, office/outpatient <i>Up to 30-day supply</i>	Tier A: 20% of AA after deductible. No maximum copayment Tier B: 30% of AA after deductible. No maximum copayment	40% of AA after deductible
Specialty Medications, through specialty vendor Accredo <i>Up to 30-day supply</i>	Tier A: 20% of AA after deductible. \$150 maximum copayment Tier B: 30% of AA after deductible. \$225 maximum copayment	Not covered
MISCELLANEOUS SERVICES		
Adoption <i>See limitations</i>	No charge after deductible, up to \$4,000 per adoption	No charge after deductible, up to \$4,000 per adoption
Affordable Care Act Preventive Services <i>See Master Policy for complete list</i>	No charge	40% of AA after deductible
Allergy Serum	20% of AA after deductible	40% of AA after deductible
Chiropractic Care <i>Up to 10 visits per plan year</i>	Applicable office copayment per visit	40% of AA after deductible
Durable Medical Equipment, DME <i>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 pre-authorization. Maximum limits apply on many items. See the Master Policy for benefit limits</i>	20% of AA after deductible	40% of AA after deductible
Medical Supplies	20% of AA after deductible	40% of AA after deductible
Home Health/Skilled Nursing <i>Up to 60 visits per plan year. Requires pre-authorization and Medical Case Management</i>	20% of AA after deductible	40% of AA after deductible
Infertility Services <i>Select services only. See the Master Policy</i>	50% of AA after deductible	70% of AA after deductible
Injections <i>Requires pre-authorization if over \$750</i>	20% of AA after deductible	40% of AA after deductible
Temporomandibular Joint Dysfunction <i>Up to \$1,000 lifetime maximum</i>	50% of AA after deductible	70% of AA after deductible

***Some services on your plan are payable at a reduced benefit of 50% of Allowed Amount or 30% of Allowed Amount. These services do not apply to any Out-of-Pocket Maximum. Deductible may apply. Refer to the Advantage, Summit, or Preferred Care Provider Plan Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.*

Non-contracted providers may charge more than the Allowed Amount unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.