Look inside for an overview of your benefits and what’s new for the 2018-19 plan year.
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**

»Website ......................... [www.pehp.org](http://www.pehp.org)

Create an online personal account at www.pehp.org to review your claims history, receive important information through our Message Center, see a comprehensive list of your coverages, use the Cost & Quality Tools to find providers in your network, access Healthy Utah rebate information, check your FLEX$ account balance, and more.

**CUSTOMER SERVICE**

………………………………. 801-366-7555  
………………………………. or 800-765-7347

Weekdays from 8 a.m. to 5:30 p.m. Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

**PREAUTHORIZATION**

»Inpatient hospital preauth. ............. 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 Customer Service ............. 801-366-7555  
………………………………. or 800-765-7347

»Express Scripts ..................... 800-903-4725  
……………………………… [www.express-scripts.com](http://www.express-scripts.com)

**SPECIALTY PHARMACY**

»Accredo ......................... 800-501-7260

**PEHP FLEX$**

»PEHP FLEX$ Department .......... 801-366-7503  
……………………………… or 800-753-7703

**HEALTH SAVINGS ACCOUNTS (HSA)**

»PEHP FLEX$ Department .......... 801-366-7503  
……………………………… or 800-753-7703

»HealthEquity ....................... 866-960-8058  
……………………………… [www.healthequity.com/stateofutah](http://www.healthequity.com/stateofutah)

**PRENATAL AND POSTPARTUM PROGRAM**

»PEHP WeeCare ....................... 801-366-7400  
……………………………… or 855-366-7400  
……………………………… [www.pehp.org/weecare](http://www.pehp.org/weecare)

**WELLNESS AND DISEASE MANAGEMENT**

»PEHP Healthy Utah ................. 801-366-7300  
……………………………… or 855-366-7300  
……………………………… [www.healthyutah.org](http://www.healthyutah.org)

»PEHP Waist Aweigh ................ 801-366-7300  
……………………………… or 855-366-7300

»PEHP Integrated Care .............. 801-366-7555  
……………………………… or 800-765-7347

**VALUE-ADDED BENEFITS PROGRAM**

»PEHPplus ......................... [www.pehp.org/plus](http://www.pehp.org/plus)

»Blomquist Hale ...................... 800-926-9619  
……………………………… [www.blomquisthale.com](http://www.blomquisthale.com)

**CLAIMS MAILING ADDRESS**

PEHP  
560 East 200 South  
Salt Lake City, UT 84102-2004
Open Enrollment

April 9-May 15 » This is the time to enroll in or make changes to your benefits. If you want to keep your current selections, you don’t have to do anything. However, take this time to review your choices and learn more about the PEHP benefits available to you.

Highlights: 2018-19 Plan Year

On-Demand Doctors
See a doctor via mobile or web with discounted pricing through Intermountain Connect Care. It’s available 24 hours a day, every day, and you don’t need an appointment.

PEHP Value Clinics
Make one of these full-service clinics your family doctor and save! They provide all the services of a family doctor, but at a lower cost.

Durable Medical Equipment
Prior to July 1, 2018, sleep disorder equipment (CPAP, BIPAP machines) required a 10-month rent-to-purchase. Starting July 1, members can now purchase sleep disorder equipment without a required rental period. The $2,500 maximum for the equipment and supplies has also been altered to one machine in a 5-year period, and supplies limited to $325 per plan year. All prior limits will not apply and new limits will reset on July 1.

Autism Benefit
Autism benefit details are included in this book.

STAR Plan Individual Cap
As part of the Affordable Care Act (ACA), when services are provided by an in-network provider, individual members cannot spend more than $7,350 on family STAR plans.

FLEX$ Coverage
Reminder that you must enroll each year in order to maintain a FLEX$ account.

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.
Highlights: 2018-19 Plan Year

**Traditional Plan Copays**
Copays remain the same, but some services are at different copay levels to better reflect comparative costs.

**Use PEHP Cost Tools**
You can now anticipate where your doctor is likely to send your lab and how much it may cost. You can also get dollar ratings for hospitals and other facilities. Compare costs in the Provider Lookup when you log in to PEHP for Members.

**Send Secure Messages to PEHP**
Have a question or can’t find what you’re looking for online? Log in to PEHP for Members and send us your questions via the Message Center. From the homepage, find “Messages” at the top-right.

**Health Benefit Advisors**
Need help deciding which plan to choose, whether to be covered by more than one plan, or different cost options for a service? Call a PEHP Health Benefit Advisor at 801-366-7555.

**Invitro Fertilization Benefit**
Beginning July 1, 2018, Traditional and STAR Plan members have the option of using a one-time $4,000 benefit for invitro fertilization. **Preauthorization** is required. For more information, call 801-366-7755 or 800-753-7754.

**Looking for Lower Drug Costs?**
Search for coverage and pricing for any medication available through your drug benefit plan. Log in to PEHP for Members, go to MyBenefits and click on Express Scripts Personal Account. You’ll see medication prices from different pharmacies. To get the best deal, make sure you use the **PEHP Preferred Drug List.** You can call us for help, 801-366-7551 or 888-366-7551.

**Getting the Most of Your Benefits**
Take a moment to learn about your out-of-network benefit and how to get reimbursed by PEHP when you make a cash purchase.

Information in this open enrollment guide is for illustrative purposes only. See your Benefits Summary and Master Policy for complete details about your plan.
Insurance Basics » Plans

Your Health Plan » Your plan determines how PEHP pays benefits. The STAR Plan and Traditional are your choices.

Deductible » The amount you must first pay before PEHP begins to pay its portion of your claims. Family deductibles are $3,000 for The STAR Plan and $700 for the Traditional Plan.

Out-of-Pocket Maximum » The maximum you pay out-of-pocket for covered services in a plan year after which PEHP pays 100%. For a family plan, it’s $9,000 on the Traditional Plan after paying $700 deductible and $7,500 on The STAR Plan.

Co-insurance » A percentage of the cost you pay for certain services. After your deductible, you pay 20% co-insurance on most services on The STAR Plan and Traditional Plan.

Preventive Care » PEHP pays 100% of preventive care or care meant to discover a condition, rather than treat a known condition, as determined by federal law.

Co-payment (Co-pay) » A set dollar amount you pay for a service. The Traditional Plan requires specific co-payments, such as $25 or $35 for an office visit.

Covered Services » PEHP may not cover all services. We only cover those proven to be medically necessary and not experimental or investigational. We may require preauthorization, and limits may apply on certain covered benefits.

Retail Pharmacy Cost Sharing » You pay cost sharing based on the tier of drug. For Tier 1 (typically generics) you pay a $10 co-payment. For Tier 2, you pay 25% co-insurance ($25 minimum). Tier 3 is 50% co-insurance ($50 minimum). Pharmacy cost sharing applies to the deductible only on The STAR Plan, not on the Traditional Plan.
Insurance Basics » Networks

**Provider Network** » Your network determines which healthcare providers you see for the best value and most predictable costs. Choose among three – Summit, Advantage, and Preferred.

**An In-Network Provider** will charge the **In-Network Rate** for services. You may also be able to negotiate a better **Cash Rate**.

**Cash Rate** » The rate you negotiate with a provider that is less than the in-network rate. You can get credit toward your limits from PEHP for the amount you pay in cash by submitting the appropriate documentation or by your provider submitting a claim with the cash rate reflected as the billed amount. Call PEHP at 801-366-7555 for more information.

**In-Network Rate** » The amount in-network providers have agreed to accept as payment in full for services. Sometimes you’re responsible for the full in-network rate. Other times, the rate is shared or PEHP pays 100%.

**Use caution with** **Out-of-Network Providers.** You may be **Balance Billed**. **PEHP pays no benefits for No-Pay Providers.**

**Balance Billing** » When you receive services from an out-of-network provider who seeks payment for full billed charges.

**Out-of-Network Provider** » Any provider not contracted with your network. Your plan may pay limited benefits for out-of-network providers. But you are responsible for any amount charged above the in-network rate; this is called balance billing.

**No-Pay Providers** » Providers for which PEHP pays no benefits.
Medical Networks

Summit

Steward Health*, MountainStar, and University of Utah Health Care providers and facilities. You can also see Advantage providers on the Summit network, but your benefits will pay less.

Participating Hospitals

<table>
<thead>
<tr>
<th>Beaver County</th>
<th>Salt Lake County (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaver Valley Hospital</td>
<td>Jordan Valley Hospital - West</td>
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<tr>
<td></td>
<td>Lene Peak Hospital</td>
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<tr>
<td></td>
<td>Primary Children’s Medical Center</td>
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<td></td>
<td>Riverton Children’s Unit</td>
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<td></td>
<td>St. Mark’s Hospital</td>
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<td></td>
<td>Salt Lake Regional Medical Center</td>
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<td></td>
<td>University of Utah Hospital</td>
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<td>University Orthopaedic Center</td>
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<td>Box Elder County</td>
<td>San Juan County</td>
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<tr>
<td>Bear River Valley Hospital</td>
<td>Blue Mountain Hospital</td>
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<tr>
<td>Brigham City Community Hospital</td>
<td>San Juan Hospital</td>
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<tr>
<td>Cache County</td>
<td>Duchesne County</td>
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<tr>
<td>Cache Valley Hospital</td>
<td>Gunnison Valley Hospital</td>
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<td>Sanpete Valley Hospital</td>
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<tr>
<td>Carbon County</td>
<td>Sevier County</td>
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<td>Castleview Hospital</td>
<td>Summit County</td>
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<td>Park City Medical Center</td>
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<td>Davis County</td>
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<td>Lakewy Hospital</td>
<td>Mountain West Medical Center</td>
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<td>Davis Hospital</td>
<td>Uintah County</td>
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<td>Ashley Valley Medical Center</td>
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<td>Davis Hospital</td>
<td>Kent County Hospital</td>
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<td>Duchesne County</td>
<td>Millard County</td>
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<td>Uintah Basin Medical Center</td>
<td>Delta Community Hospital</td>
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<td>Garfield County</td>
<td>Salt Lake County</td>
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<td>Garfield Memorial Hospital</td>
<td>Alta View Hospital</td>
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<td>Intermountain Medical Center</td>
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<td>Grand County</td>
<td>Utah County</td>
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<tr>
<td>Moab Regional Hospital</td>
<td>Mountain View Hospital</td>
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<td></td>
<td>Timpanogos Regional Hospital</td>
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<td></td>
<td>Mountain Point Medical Center</td>
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<td>Iron County</td>
<td>Wasatch County</td>
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<tr>
<td>Cedar City Hospital</td>
<td>Heber Valley Medical Center</td>
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<tr>
<td>Juab County</td>
<td>Washington County</td>
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<tr>
<td>Central Valley Medical Center</td>
<td>Dixie Regional Medical Center</td>
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<tr>
<td>Kane County</td>
<td>Weber County</td>
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<tr>
<td>Kane County Hospital</td>
<td>Ogden Regional Medical Center</td>
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<td>Millard County</td>
<td>Salt Lake County</td>
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<tr>
<td>Delta Community Hospital</td>
<td>Intermountain Medical Center</td>
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<tr>
<td>Fillmore Community Hospital</td>
<td>University Orthopaedic Center</td>
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<tr>
<td>Salt Lake County</td>
<td>St. George Regional Medical Center</td>
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<tr>
<td>Huntsman Cancer Hospital</td>
<td>Salt Lake Regional Medical Center</td>
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<tr>
<td>Jordan Valley Hospital</td>
<td>University of Utah Hospital</td>
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<td>Washington County</td>
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<td>Weber County</td>
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No-Pay Providers

PEHP doesn’t pay for any services from certain providers, even if you have an out-of-network benefit. See List of No-Pay Providers

Advantage

Intermountain Healthcare (IHC) providers and facilities. You can also see Summit providers on the Advantage network, but your benefits will pay less.

Participating Hospitals

<table>
<thead>
<tr>
<th>Beaver County</th>
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<tbody>
<tr>
<td>Beaver Valley Hospital</td>
<td>The Orthopedic Specialty Hospital (TOSH)</td>
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<tr>
<td></td>
<td>LDS Hospital</td>
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<tr>
<td></td>
<td>Primary Children’s Medical Center</td>
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<td>McKay-Dee Hospital</td>
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<td>Delta Community Hospital</td>
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<td>Fillmore Community Hospital</td>
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</tbody>
</table>

Preferred

Consists of all providers and facilities in both the Summit and Advantage networks.

» Learn More About Your Network

*Formerly IASIS
Network Considerations

With the Advantage network you get care at hospitals and generally pay similar prices from one to another. With the Summit network, some services are available only at hospitals, while others are also available at surgical or imaging centers with prices varying from one facility to the next. With both networks you get access to doctors’ offices, where prices can vary. The Summit network also provides rebates for certain procedures (see your Benefits Summary).

### ADVANTAGE
Price estimates for Intermountain Healthcare hospitals

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Doctor’s Office</th>
<th>Surgery/Imaging Center</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysteroscopy</td>
<td>$568-1,247</td>
<td>Not Available</td>
<td>$4,060-7,678</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$851-1,031</td>
<td>$871-926</td>
<td>$1,702-2,469</td>
</tr>
<tr>
<td>MRI of Head</td>
<td>$552-584</td>
<td>Not Available</td>
<td>$2,053-2,591</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>Not Available</td>
<td>$3,872-5,068</td>
<td>$4,901-6,345</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>Not Available</td>
<td>Not Available</td>
<td>$33,771-35,570</td>
</tr>
<tr>
<td>Maternity - delivery</td>
<td>Not Available</td>
<td>Not Available</td>
<td>$9,222-10,893</td>
</tr>
</tbody>
</table>

### SUMMIT
Price ranges for Steward Health (formerly IASIS), MountainStar, University of Utah, surgical centers, imaging centers

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Doctor’s Office</th>
<th>Surgery/Imaging Center</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysteroscopy</td>
<td>$663-1,060</td>
<td>$1,867-2,044</td>
<td>$4,004-7,027</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$791-1,031</td>
<td>$1,513-1,658</td>
<td>$2,218-2,872</td>
</tr>
<tr>
<td>MRI of Head</td>
<td>$550-594</td>
<td>$550-594</td>
<td>$2,046-2,248</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>Not Available</td>
<td>$2,370-2,926</td>
<td>$4,455-6,572</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>Not Available</td>
<td>$14,627-23,487</td>
<td>$27,805-37,067</td>
</tr>
<tr>
<td>Maternity - delivery</td>
<td>Not Available</td>
<td>Not Available</td>
<td>$8,512-10,918</td>
</tr>
</tbody>
</table>

*For illustrative purposes only. Based on PEHP average-cost data from December 2017. Costs may vary. Estimates shown reflect the total cost — not necessarily your portion of the cost.

### Using Your Out-of-Network Benefit
Under this benefit, PEHP credits up to 100% of the in-network rate toward your remaining deductible for services from a non-contracted provider. Once you reach your deductible, PEHP pays 20% less than normal, including after you reach your out-of-pocket maximum. This ensures you receive some benefit when you either mistakenly or purposefully use a non-contracted provider. Because there is no contract with PEHP, you may be subject to balance billing unless you have negotiated a price with the provider.

### Seeking Reimbursement for Cash Payments
You may elect to pay cash for covered medical services. Check your Benefits Summary to see which services are allowed out-of-network. When you do obtain eligible services, just submit your receipt to PEHP for reimbursement or credit towards your deductible. PEHP will follow the same process and rules in paying for the claim as if submitted by a provider. For services beyond what PEHP covers, see if you can use HSA or Flex funds, which come under much broader IRS rules.
Consult a Doctor Remotely with Intermountain Connect Care

**A Fast, Easy Way to See a Doctor**

Connect Care gives families access to care 24/7/365 (even on holidays) for urgent, low-level needs such as:

- Allergies
- Sore throat
- Eye infections
- Cough
- Painful urination
- Lower back pain
- Joint pain or strains
- Minor skin problems

**Available on all PEHP networks**

- Advantage
- Preferred
- Summit

If You’re on a Traditional Plan

Each on-demand doctor consultation costs only a **$10 co-pay**.

If You’re on The STAR Plan

Each on-demand doctor consultation costs only **$49** before you meet your deductible. After your deductible is met, you pay only a **$10 co-pay**.

Download the app from the [Google Play Store](https://play.google.com/store) or [iTunes App Store](https://itunes.apple.com).
Value Providers

MEDICAL

The STAR Plan: 25% discount on what you would normally pay an in-network provider
Traditional Plan: $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 | 801-506-0000

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 | 801-395-6499

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

INTERMOUNTAIN CONNECT CARE
Available on all PEHP networks.

The STAR Plan: $49 per visit or $10 per visit after deductible.
Traditional Plan: $10 per visit

Visit a doctor online anytime, anywhere.
- Stuffy and runny nose
- Allergies
- Sore throat
- Eye infections
- Cough
- Painful urination
- Lower back pain
- Joint pain or strains
- Minor skin problems

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.
Get Cash Back  » Get $55* cash back when you get your colonoscopy from one of these Value providers. You need to get the colonoscopy in the provider’s office or at an ambulatory surgical center to be eligible for $55 as this doesn’t apply to hospitals, even if your doctor determines you must do it there. Remember you’ll always get the best pricing when you use a PEHP Value Provider.

Utah Gastroenterology

*Benefit isn’t available to Salt Lake County employees. Salt Lake City employees will receive $55 tax-free in an HSA. For all others, the cash back is subject to income taxes.

Preventive Colonoscopy 50+

The cash back applies even when it’s preventive and covered at 100%.

Tip: Be sure the anesthesia is considered “moderate or conscious” sedation as general anesthesia isn’t covered as part of the preventive service unless pre-authorized through PEHP. Also be aware that sometimes the colonoscopy can result in additional treatment or diagnosis where you would be responsible for some of the cost based on your benefit cost share.

Granite Peaks Gastroenterology
- 1393 E Sego Lily Dr., Sandy
- 3000 N Triumph Blvd Ste 330, Lehi

Revere Health
- 1055 N. 500 W., Provo
- 1175 E. 50 S., American Fork

PEHP has identified several medication-assistance programs which may help to reduce the cost of your medication. See if you may qualify.

Rx Help Centers®
http://rxhelpcenter.org/

Patient Advocate Foundation®
http://www.patientadvocate.org/

Patient Access Network Foundation®

HealthWell Foundation®
https://www.healthwellfoundation.org/
Value Providers

LABORATORIES

Visit these labs for exclusive PEHP member savings.

MULTIPLE LOCATIONS
The following laboratories have more than one location. For the location near you, visit the Provider Lookup at www.pehp.org.

- **Accupath Diagnostics**
  Advantage and Summit networks

- **Cedar Diagnostics LLC**
  Advantage and Summit networks

- **Esoterix**
  Advantage network only

- **Labcorp Inc**
  Advantage and Summit networks

- **Pathology Associates Medical Labs**
  Summit network only

- **Quest Diagnostics**
  Summit network only

- **BOUNTIFUL**
  **Bountiful Health Center Lab**
  390 N Main St. | 801-294-1150
  Advantage network only

- **MURRAY**
  **Intermountain Central Lab**
  5252 S Intermountain Dr. | 801-535-8163
  Summit network only

- **SALT LAKE CITY**
  **IHC Health Center Salt Lake Clinic**
  333 S 900 E | 801-535-8163
  Advantage and Summit networks

- **OUT-OF-STATE**
  **ALBUQUERQUE, N.M.**
  **Tricore Reference Laboratories**
  1001 Woodward Pl. NE | 505-938-8803
  Summit network only

DENTAL

10% discount on what you would normally pay an in-network provider.

- **SALT LAKE CITY**
  **Family Dental Plan**

- **OGDEN**
  **Family Dental Plan**
  950 25th Street, #A | 801-395-7090

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.
Take Control of Your Healthcare Costs
Get the right service at the right place

Where you get healthcare matters. Rates are always higher for medical services done at a hospital. Some services can only be done at a hospital but others, such as lab work, radiology, elective surgeries, and urgent care can be done in other settings.

For lab work, let your doctor know you want to use an independent lab, like Labcorp, that will forward the results to your doctor.

For radiology and certain elective surgeries, consider seeking services outside of a hospital for substantial savings. For example, you could save $1,442 for an MRI at a large multi-specialty clinic like:

- Revere Health
- Granger Clinic
- Tanner Clinic
- Ogden Clinic

If you don’t have a medical emergency but need immediate medical attention, visit the nearest Urgent Care Clinic. Also, consider consulting a doctor online through your E-Care benefit for convenient 24/7 urgent care. Intermountain Connect Care is PEHP’s preferred E-Care provider for all networks, including Summit.

- **Office Visit**
  - Not life-threatening
  - Can be seen during usual business hours
  - Can wait for an appointment

- **E-Care**
  - Stuffy and runny nose
  - Sore throat
  - Allergies
  - Cough
  - Eye infections
  - Painful urination

- **Primary Care**
  - Common, non-life-threatening conditions
  - Broken bones
  - Minor cuts
  - Minor burns
  - Cold/flu symptoms after hours

- **Specialty Care**
  - Evaluation of an assault, physical or sexual abuse, or child abuse
  - Severe infection
  - Complications of early pregnancy
  - Abdominal pain that is severe or with repeated and persistent vomiting
  - If you are unsure whether you are having a life-threatening medical emergency

- **Urgent Care**
  - Chest pain or pressure
  - Severe headache or head injury
  - Severe bleeding
  - Sudden or severe pain
  - Coughing blood or vomiting blood
  - Difficulty breathing or shortness of breath
  - Sudden dizziness, weakness, or changes in vision
  - Severe or persistent vomiting or diarrhea
  - Changes in mental status, such as confusion or weakness
  - Evaluation of an assault, physical or sexual abuse, or child abuse
  - Severe infection
  - Complications of early pregnancy
  - Abdominal pain that is severe or with repeated and persistent vomiting
  - If you are unsure whether you are having a life-threatening medical emergency

- **Emergency Room**
  - Chest pain or pressure
  - Severe headache or head injury
  - Severe bleeding
  - Sudden or severe pain
  - Coughing blood or vomiting blood
  - Difficulty breathing or shortness of breath
  - Sudden dizziness, weakness, or changes in vision
  - Severe or persistent vomiting or diarrhea
  - Changes in mental status, such as confusion or weakness
  - Evaluation of an assault, physical or sexual abuse, or child abuse
  - Severe infection
  - Complications of early pregnancy
  - Abdominal pain that is severe or with repeated and persistent vomiting
  - If you are unsure whether you are having a life-threatening medical emergency

Where You Get Healthcare
PEHP Cost & Quality Tools

Shop, Compare, and Save Money on Healthcare! As a PEHP member, you have access to powerful cost transparency tools to find the best care and value. Log in today and take the mystery out of healthcare pricing.

**Treatment Cost Calculator**
Are you expecting a baby, do you need surgery, are you managing a chronic condition? The cost calculator has price estimates for more than 300 procedures. Compare expected costs among providers. Customized estimates are based on your benefits.

**Provider Costs**
Transparency starts with when you search for a doctor. Use our provider costs tool to find healthcare providers in your network. It’s more than just a simple provider search. Get cost information, reviews from other PEHP members, cautionary notes from PEHP, and more.

**Price a Medication**
Price medications and see the sometimes-dramatic cost differences among equivalent drugs, based on your specific benefits.

**Cost-Saving Tips**
Check often for tips to save money and avoid unexpected bills.

Find these innovative tools at PEHP for Members at www.pehp.org. Find them under the Cost & Quality Tools logo in the bottom left of the page.
Autism Spectrum Disorder Benefit

A brief overview of PEHP’s Autism Spectrum Disorder coverage

Children ages 2-9 (stops on 10th birthday) are eligible for the benefit, which covers up to 600 hours per year of behavioral health treatment.

» Please call PEHP (801-366-7555 or 800-765-7347) for information about which autism spectrum disorders and services are covered.

» Therapeutic care includes services provided by speech therapists, occupational therapists, or physical therapists.

» Eligible Autism Spectrum Disorder services do not accrue separately, and are subject to the medical plan’s visit limits, regular cost sharing limitations – deductibles, co-payments, and coinsurance – and would apply to the out-of-pocket maximum.

» Mental health and speech therapy services require Preauthorization.

» No benefits for services received from out-of-network Providers. List of in-network providers is available at PEHP for Members at www.pehp.org or by calling PEHP (801-366-7555 or 800-765-7347).

» Regular medical benefits will apply (see benefits grid for applicable co-pay and coinsurance).
**Medical Benefits**

**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.
### Medical Benefits

#### Professional Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Physician Visits</td>
<td>Applicable office co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Surgery and Anesthesia</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>PEHP e-Care</td>
<td>Medical: $10 co-pay per visit. Mental Health: Standard benefits apply. See PEHP Value Options benefits page for details</td>
<td>Not applicable</td>
</tr>
<tr>
<td>PEHP Value Clinics</td>
<td>Medical: $10 co-pay per visit</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Primary Care Office Visits</td>
<td>$25 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Intermountain or University of Utah Medical Group</td>
<td>$35 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>$35 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Intermountain or University of Utah Medical Group</td>
<td>$45 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Emergency Room Specialist</td>
<td>$35 co-pay per visit</td>
<td>$35 co-pay per visit, plus any balance billing above In-Network Rate</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>$35 co-pay per visit</td>
<td>Outpatient: 40% of In-Network Rate after deductible Inpatient: 40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>No preauthorization required for outpatient services. Inpatient services require preauthorization</td>
<td>Intermountain or University of Utah Medical Group: $45 co-pay per visit</td>
<td></td>
</tr>
</tbody>
</table>

#### Prescription Drugs

<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1:</th>
<th>Tier 2:</th>
<th>Tier 3:</th>
<th>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day Pharmacy Retail only</td>
<td>$10 co-pay</td>
<td>25% of discounted cost. $25 minimum, no maximum co-pay</td>
<td>50% of discounted cost. $50 minimum, no maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>30-day Pharmacy Maintenance only</td>
<td>$20 co-pay</td>
<td>25% of discounted cost. $50 minimum, no maximum co-pay</td>
<td>50% of discounted cost. $100 minimum, no maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, retail pharmacy Up to 30-day supply</td>
<td>Tier A: 20%. No maximum co-pay</td>
<td>Tier B: 30%. No maximum co-pay</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, office/outpatient Up to 30-day supply</td>
<td>Tier A: 20% of In-Network Rate after deductible. No maximum co-pay</td>
<td>Tier B: 30% of In-Network Rate after deductible. No maximum co-pay</td>
<td>Tier A: 40% of In-Network Rate after deductible. Tier B: 50% of In-Network Rate after deductible.</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, through specialty vendor Accredo</td>
<td>Tier A: 20%. $150 maximum co-pay</td>
<td>Tier B: 30%. $225 maximum co-pay</td>
<td>Tier C: 20%. No maximum co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.**

<table>
<thead>
<tr>
<th>MISCELLANEOUS SERVICES</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption or Assisted Reproductive Technology (ART)</td>
<td>20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART</td>
<td></td>
</tr>
<tr>
<td>Affordable Care Act Preventive Services</td>
<td>No charge</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>See Master Policy for complete list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>20% of In-Network Rate after deductible</td>
<td>20% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Up to 10 visits per plan year</td>
<td>Applicable office co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dental Accident</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment, DME</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>See the Master Policy for benefit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health/Skilled Nursing</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Up to 60 visits per plan year. Requires preauthorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services**</td>
<td>50% of In-Network Rate after deductible</td>
<td>70% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Select services only. See the Master Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Requires preauthorization if over $750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction**</td>
<td>50% of In-Network Rate after deductible</td>
<td>70% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Up to $1,000 lifetime maximum</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PEHP FLEX$

Time to Get Serious About Reducing Out-of-Pocket Costs »
At open enrollment, you agree to set aside a portion of your pre-tax salary for the year to pay eligible expenses. PEHP offers two types of FLEX$: healthcare and dependent day care. Enroll in one or both.

Plan Year Contribution Limits
» Up to $2,650 for healthcare expenses (May adjust annually for inflation)
» Up to $5,000 for dependent day care expenses (you and your spouse combined)

How You Contribute
» Your contributions are withheld from your paycheck pre-tax. The total amount you contribute is evenly divided among pay periods.
» The total amount you choose to withhold for healthcare expenses is immediately available as soon as you begin FLEX$.

You Can’t Have an HSA
You can’t contribute to a health savings account (HSA) while you’re enrolled in healthcare FLEX$. However, you may have a dependent day care FLEX$ and/or a limited FSA and contribute to an HSA.

FLEX$ Timeline
Eligible FLEX$ expenses must be incurred between July 1, 2018 and September 15, 2019. You must submit claims by September 30, 2019.

Dependent Day Care FLEX$
» Available for STAR and traditional plans.
» Can be added within 60 days of a qualifying event (as daycare needs change).
» Up to $5,000 dependent daycare expenses (you and your spouse).
» Dollars are deducted from your paycheck and become available when PEHP receives the funds.

Learn More
Contact PEHP FLEX$: 801-366-7503 or 800-753-7703; email: flex@pehp.org.
See instructions below to download the PEHP FLEX$ brochure or email publications@pehp.org to request a copy.
The STAR Plan: What Is It?
The STAR Plan has two components: 1) A High Deductible Health Plan (HDHP), which is a qualified medical plan that meets IRS guidelines for deductibles and out-of-pocket maximums; and 2) a Health Savings Account (HSA), which is an interest-bearing account designed to be coupled with an HDHP.

Do You Qualify?
To be eligible, you must enroll in The STAR Plan. Also, the following things must apply to you:
- You’re not participating in or covered by a general-purpose flex account (FSA) or Health Reimbursement Account (HRA) or their balances will be $0 on or before June 30.
- You’re not covered by another health plan (unless it’s another HSA-qualified plan).
- You’re not covered by Medicare, Tricare or Medicaid.
- You’re not a dependent of another taxpayer.

How It Works
**YOUR HSA**
A Health Savings Account is a tax-advantaged, interest-bearing account.
Your money goes in tax-free, grows tax-free, and is spent on qualified health expenses tax-free.
It’s a great way to save for health expenses in both the short and long term.

An HSA is like a flexible spending account, but better. You never have to worry about forfeiting HSA money you don’t spend.
Money in your HSA carries over from year-to-year and even from employer-to-employer.

**YOUR DEDUCTIBLE**
Your deductible is the yearly dollar amount you must pay out of your own pocket for eligible medical and pharmacy expenses before PEHP begins paying benefits. The STAR Plan’s deductible is set higher than Advantage and Summit Care’s.

Your Out-of-Pocket Max: What Is It?
It’s the annual dollar limit you will pay for covered medical services, including your deductible and prescription expenses. It protects you from large dollar claims, capping the amount you’re responsible to pay each plan year.
Eligible HSA expenses include deductibles, copayments, and coinsurance, as well as all flex-eligible health expenses. However, while many expenses are HSA-eligible, they apply to your deductible and out-of-pocket maximum only if they’re covered by your health plan.

Debit Card
You’ll be automatically issued a debit card to access your HSA funds. Always present your PEHP card at the time of service to receive PEHP’s discounted rate. It also allows PEHP to track your spending to apply to your deductible and out-of-pocket maximum.

Banking
Health Equity will handle your HSA. Weber State University will make your HSA contributions directly to Health Equity into your account. You are responsible for the management of your HSA funds.

You’ll automatically get this HSA debit card at no cost to you.
**Advantage & Summit Plan Comparison: STAR vs. Traditional**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>STAR</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the deductible apply to the out-of-pocket maximum?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the deductible apply to inpatient and outpatient services?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the deductible apply to physician office copays?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Will WSU contribute to my HSA?</td>
<td>Yes</td>
<td>Not Eligible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>STAR</th>
<th>Traditional</th>
</tr>
</thead>
</table>
| Employee semi-monthly cost for medical benefits                          | $0                            | Individual: $28.32  
Double: $58.40  
Family: $77.95  
(Rates for Summit & Advantage plans only) |
| WSU semi-monthly Contribution                                            | Semi-monthly:  
Single: $33.09  
Double: $66.18  
Family: $66.18 |
|                                                                         |                               | Not Eligible |
| Out-of-pocket Maximum                                                    | Medical & RX:  
Single: $2,500  
Double: $5,000  
Family: $7,500 |
|                                                                         | Medical & RX:  
Single: $3,000  
Double: $6,000  
Family: $9,000 |

**Contributions**

The contribution maximum applies to the IRS calendar year (Jan-Dec). If you become ineligible for The STAR Plan during the course of the IRS calendar year and contributions have been made to your HSA, you may be subject to taxes and penalties. If you exceed the contribution maximum during the IRS calendar year and then drop the STAR Plan during Weber State’s open enrollment period you may be subject to taxes and penalties.
Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

### DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS

<table>
<thead>
<tr>
<th></th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Year Deductible</strong></td>
<td>$1,500 single plan, $3,000 double or family plan</td>
<td>$2,500 single plan, $5,000 double plan, $7,500 family plan</td>
</tr>
<tr>
<td><strong>Plan Year Out-of-Pocket Maximum</strong></td>
<td>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.</td>
<td>$2,500 single plan, $5,000 double plan, $7,500 family plan</td>
</tr>
</tbody>
</table>

### INPATIENT FACILITY SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network Rate after deductible</th>
<th>Out-of-Network Rate after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Hospice</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### OUTPATIENT FACILITY SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network Rate after deductible</th>
<th>Out-of-Network Rate after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility and Ambulatory Surgery</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Ambulance (ground or air)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20%</td>
<td>20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Minor</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Chemotherapy, Radiation, and Dialysis</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

*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.
## Medical Benefits

<table>
<thead>
<tr>
<th>PROFESSIONAL SERVICES</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Physician Visits</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Surgery and Anesthesia</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>PEHP e-Care</td>
<td>Medical: $10 co-pay per visit after deductible. Mental Health: Standard benefits apply after deductible. See PEHP Value Options benefits page for details</td>
<td>Not applicable</td>
</tr>
<tr>
<td>PEHP Value Clinics</td>
<td>Medical: 20% of In-Network Rate after deductible</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Primary Care Office Visits and Office Surgeries</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Specialist Office Visits and Office Surgeries</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Emergency Room Specialist</td>
<td>20% of In-Network Rate after deductible</td>
<td>20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>Outpatient: 20% of In-Network Rate after deductible</td>
<td>Outpatient: 40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>No preauthorization required for outpatient services. Inpatient services require preauthorization</td>
<td>Inpatient: 20% of In-Network Rate after deductible</td>
<td></td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td>All pharmacy benefits for The STAR Plan are subject to the deductible</td>
<td></td>
</tr>
<tr>
<td>30-day Pharmacy</td>
<td>Tier 1: $10 co-pay</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</td>
</tr>
<tr>
<td>Retail only</td>
<td>Tier 2: 25% of discounted cost.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3: 50% of discounted cost. $50 minimum, no maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>90-day Pharmacy</td>
<td>Tier 1: $20 co-pay</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</td>
</tr>
<tr>
<td>Maintenance only</td>
<td>Tier 2: 25% of discounted cost.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3: 50% of discounted cost. $100 minimum, no maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, retail pharmacy</td>
<td>Tier A: 20%. No maximum co-pay</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</td>
</tr>
<tr>
<td>Up to 30-day supply</td>
<td>Tier B: 30%. No maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, office/outpatient</td>
<td>Tier A: 20% of In-Network Rate.</td>
<td>Tier A: 40% of In-Network Rate.</td>
</tr>
<tr>
<td>Up to 30-day supply</td>
<td>No maximum co-pay</td>
<td>Tier B: 50% of In-Network Rate.</td>
</tr>
<tr>
<td></td>
<td>Tier B: 30% of In-Network Rate.</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, through specialty vendor Accredo</td>
<td>Tier A: 20%. $150 maximum co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Up to 30-day supply</td>
<td>Tier B: 30%. $225 maximum co-pay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier C: 20%. No maximum co-pay</td>
<td></td>
</tr>
<tr>
<td>MISCELLANEOUS SERVICES</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider*</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Adoption or Assisted Reproductive Technology (ART)</td>
<td>20% after deductible, up to $4,000 per adoption or up to $4,000 per lifetime for ART</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Affordable Care Act Preventive Services</td>
<td>No charge</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>20% of In-Network Rate after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dental Accident</td>
<td>20% of In-Network Rate after deductible</td>
<td>20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate</td>
</tr>
<tr>
<td>Durable Medical Equipment, DME</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Home Health/Skilled Nursing</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>50% of In-Network Rate after deductible</td>
<td>70% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Injections</td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction</td>
<td>50% of In-Network Rate after deductible</td>
<td>70% of In-Network Rate after deductible</td>
</tr>
</tbody>
</table>
PEHP Limited FLEX$  

**Enrolling in a Limited FSA**
If you are enrolled in The STAR Plan, you can also choose to enroll in a Limited Purpose Flexible Spending Account. This is a tax savings account.
The pre-tax monies you choose to fund this account can be used for eligible dental and vision expenses, and after you have met The STAR Plan deductible you can use these funds for eligible medical expenses.

**Plan Year Contribution Limits**
» Up to $2,650 for dental and vision expenses (May adjust annually for inflation)

**How You Contribute**
» Your contributions are withheld from your paycheck pre-tax. The total amount you contribute is evenly divided among pay periods.
» The total amount you choose to withhold for dental and vision expenses is immediately available as soon as you begin FLEX$.

**You Can Have an HSA**
Unlike a healthcare FLEX$ account, a Limited FLEX$ account allows you to contribute to a health savings account (HSA) while you’re enrolled. You may have a dependent day care FLEX$ and contribute to an HSA also.

**FLEX$ Timeline**
*Eligible FLEX$ expenses must be incurred between July 1, 2018 and September 15, 2019. You must submit claims by September 30, 2019.*

**Remember**
The funds in this account are use or lose. The maximum you can deposit is $2,650 for the plan year. Remember, as an enrollee in the STAR Plan, you are also enrolled in the Health Savings Account (HSA).

**Learn More**
Contact PEHP FLEX$: 801-366-7503 or 800-753-7703; email: flex@pehp.org.
See instructions below to download the PEHP FLEX$ brochure or email publications@pehp.org to request a copy.
PEHP Pays for Preventive Benefits at 100%*

Don’t put off that test or immunization. Preventive benefits are covered at no cost to you when you see a contracted provider — even before you meet your deductible. This applies to both The STAR Plan and Traditional plan.

Covered Preventive Services for Adults
(Ages 18 and older)

» Preventive physical exam visits for adults, one time per plan year including:
  › Blood pressure screening
  › Basic/comprehensive metabolic panel
  › Complete blood count
  › Urinalysis
  › Abdominal aortic aneurysm one-time screening for men aged 65-75 who have ever smoked.
  › Alcohol misuse screening and counseling.
  › Aspirin use for men ages 45-79 and women ages 55-79, covered under the pharmacy benefit when prescribed by a physician.
  › Cholesterol screening for adults of certain ages or at higher risk.
  › Colorectal cancer screening for adults ages 50 to 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
  › Depression screening for adults.
  › Type 2 diabetes screening for adults with high blood pressure.
  › Diet counseling for adults at higher risk for chronic disease including hyperlipidemia, obesity, diabetes, and cardiovascular disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists including registered dietitians.
  › HIV screening for all adults at higher risk.
  › Immunization vaccines for adults — doses, recommended ages, and recommended populations vary:
    › Hepatitis A
    › Hepatitis B
    › Herpes zoster (shingles age 60 and above)
    › Human papillomavirus (HPV)
    › males age 9-21 Gardasil
    › females age 9-26 Gardasil or Cervarix
    › Influenza (flu shot)
    › Measles, mumps, rubella
    › Meningococcal (meningitis)
    › Pneumococcal (pneumonia)
    › Tetanus, diphtheria, pertussis (Td or Tdap)
    › Varicella (chickenpox)
  Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.
  › Obesity screening and counseling for all adults by primary care clinicians to promote sustained weight loss for obese adults.
  › Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
  › Tobacco use screening for all adults and cessation interventions for tobacco users.
  › Syphilis screening for all adults at higher risk.

Covered Preventive Services Specifically for Women, Including Pregnant Women

» Preventive gynecological exam, two per plan year.
» Anemia gynecological exam, two per plan year.
» Bacteriuria urinary tract or other infection screening for pregnant women.
» BRCA counseling about genetic testing for women at higher risk.
» BRCA testing for women at higher risk, requires preauthorization from PEHP.
» Breast cancer mammography screenings one time per plan year for women over 40. PEHP does not cover 3D mammography.
» Breast cancer chemoprevention counseling for women at higher risk.
» Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
» Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
Coverage allows for either a manual or electric breast pump within 12 months after delivery. Hospital grade breast pumps when medically necessary and preauthorized by PEHP are also included.
» Cervical cancer screening (pap smear) for pregnant women ages 21-65.

Continued on back
> Syphilis screening for all pregnant women or treatment are not considered preventive services and are subject to the appropriate cost sharing.

> Behavioral assessments for children of all ages;
> Blood pressure screening for children;
> Developmental screening for children under age 3 and surveillance throughout childhood;
> Oral health risk assessment for young children;
> Alcohol and drug use assessments for adolescents.

> Autism screening for children at 18 and 24 months.
> Cervical dysplasia (pap smear) screening for sexually active females.
> Congenital hypothyroidism screening for newborns.
> Depression screening for adolescents.
> Dyslipidemia screening for children at higher risk of lipid disorders.
> Fluoride chemoprevention supplements for children without fluoride in their water source.
> Gonorrhea preventive medication for the eyes of all newborns.
> Hearing screening for all newborns, birth to 90 days old.
> Height, weight, and body mass index measurements for children.
> Hematocrit or hemoglobin screening for children.
> Hemoglobinopathies or sickle cell screening for newborns.
> HIV screening for adolescents at higher risk.
> Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
> Diphtheria, tetanus, pertussis (Dtap);
> Haemophilus influenzae type b (Hib);
> Hepatitis A;
> Hepatitis B;
> Human papillomavirus (HPV);
> Males age 9-21 Gardasil;
> Females age 9-26 Gardasil or Cervarix;
> Inactivated poliovirus;
> Influenza (Flu Shot);
> Measles, mumps, rubella;
> Meningococcal (meningitis);
> Pneumococcal (pneumonia);
> Rotavirus;
> Varicella (chickenpox).
> Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.
> Iron supplements for children ages 6 to 12 months at risk for anemia.
> Obesity screening and counseling.
> Phenylketonuria (PKU) screening for this genetic disorder in newborns.
> Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
> Tuberculin testing for children at higher risk of tuberculosis.
> Vision screening for all children one time between ages 3 and 5.

### Coverage for Specific Drugs

Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over-the-counter purchases are not covered. See applicable Benefits Summary for coverage information.

> Aspirin use for men age 45-79 and women age 55-79.
> Breast cancer medications for women at higher risk. Tamoxifen or Raloxifen.
> Folic acid supplements for women who may become pregnant.
> Fluoride chemoprevention supplements for children without fluoride in their water source.
> Iron supplements for children ages 6 to 12 months at risk for anemia.
> Tobacco use cessation interventions, up to the maximum approved dose and duration per plan year.

### Additional Preventive Services When Enrolled in The STAR Plan

(doesn’t apply to Jordan School District)
(doesn’t apply to Utah Basic Plus)

**Adults**

> Eye exam, routine. One per plan year.
> Glaucoma screening.
> Glucose test.
> Hearing exam.
> Hypothyroidism screening.
> Phenylketones test.
> Prostate cancer screening.
> PSA (prostate specific antigen) screening.
> Refraction exams.
> Blood typing for pregnant women.
> Rubella screening for all women of childbearing age.

**Children**

> Eye exam, routine. One per plan year.
> Glaucoma screening.
> Hearing exam.
> Hypothyroidism screening.
> Refraction exams.

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* PEHP processes claims based on your provider’s clinical assessment of the office visit. If a preventive item or service is billed separately, cost sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, cost sharing may apply. Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.
### Understanding Your EOBs

#### We send an EOB each time we process a claim for you or someone on your plan.

Go paperless and view EOBs at your myPEHP account at www.pehp.org.

<table>
<thead>
<tr>
<th>AMOUNT CHARGED</th>
<th>The medical provider’s (e.g., doctor, hospital, or clinic) bill for your service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMOUNT INELIGIBLE</td>
<td>The part of the bill that includes services not covered by your plan. This is between you and the provider.</td>
</tr>
<tr>
<td>AMOUNT ELIGIBLE</td>
<td>This is PEHP’s In-Network Rate. This is the most we allow in-network providers to charge for this service. However, out-of-network providers may charge more than the In-Network Rate. Avoid paying more by using only providers in your network (go to <a href="http://www.pehp.org">www.pehp.org</a>).</td>
</tr>
<tr>
<td>DEDUCTIBLE</td>
<td>The set amount you pay for eligible charges in a plan year before cost sharing takes place.</td>
</tr>
<tr>
<td>CO-INSURANCE</td>
<td>The percentage of the cost you must pay under your plan. You may already have paid this amount when you received services. If so, the provider’s bill may be lower than what’s shown on the EOB.</td>
</tr>
<tr>
<td>CO-PAY</td>
<td>The fixed dollar amount you must pay under your plan. You may already have paid this amount when you received services. If so, the provider’s bill may be lower than what’s shown on the EOB.</td>
</tr>
<tr>
<td>AMOUNT PAID</td>
<td>The part of the bill PEHP paid.</td>
</tr>
<tr>
<td>CLAIM NUMBER</td>
<td>Keep this number as reference if you call PEHP about your claim.</td>
</tr>
<tr>
<td>YOUR TOTAL RESPONSIBILITY</td>
<td>The amount of the bill the provider expects you to pay. This is between you and the provider.</td>
</tr>
<tr>
<td>CPT CODE</td>
<td>This code for the service you received can be helpful when discussing your EOB with your doctor or PEHP.</td>
</tr>
</tbody>
</table>