Look inside for an overview of your benefits and what’s new for the 2017-18 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

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

**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

**PRENATAL AND POSTPARTUM PROGRAM**

» PEHP WeeCare ............... 801-366-7400
........................................ or 855-366-7400
........................................ www.pehp.org/weecare

**WELLNESS AND DISEASE MANAGEMENT**

» PEHP Healthy Utah .......... 801-366-7300
........................................ or 855-366-7300
........................................ www.healthyutah.org

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

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

**VALUE-ADDED BENEFITS PROGRAM**

» PEHPplus ......................... www.pehp.org/plus

» Blomquist Hale ............. 800-926-9619
........................................ www.blomquisthale.com

**CLAIMS MAILING ADDRESS**

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

April 10-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.

CHANGES AND REMINDERS

**Inpatient Rehabilitation**
Inpatient rehabilitation will be limited to 45 days per plan year.

**On-Demand Doctors**
See a doctor via mobile or web with discounted PEHP pricing through Amwell On-Demand Doctors. 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.

**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 $7,150 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.

Information in this open enrollment guide is for illustrative purposes only. See your Benefits Summary and Master Policy for complete details about your plan.
Know Before You Go

Tools Help You Choose a Doctor and Understand Your Treatment »
Don’t leave your family’s health and finances to chance! PEHP gives you tools and information to be an informed healthcare consumer. Go to PEHP for Members and know before you go!

Step 1 » Use the Treatment Advisor to learn more about your condition and treatment options, and learn questions to ask your doctor.

Step 2 » Use the Treatment Cost Calculator to estimate the cost of your treatment and compare cost differences among providers.

Step 3 » Determine if PEHP Value Options, including Amwell On-Demand Doctors and PEHP Value Clinics, can treat your condition or provide a starting point.

Step 4 » Use PEHP’s Find and Select a Provider to understand potential coverage pitfalls for a particular treatment or provider type, including the need for preauthorization and specific services that may be excluded.

Step 5 » Use PEHP’s Find and Select a Provider to find a doctor in your network, read about other PEHP members’ experiences with him or her, and see notes about any relevant practice patterns or other situations of which you should be aware.

Step 6 » If you still need help figuring out what to do next, call PEHP at 801-366-7555 or 800-765-7347.

Find these innovative tools at PEHP for Members at www.pehp.org. Look for them under these menus.
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.

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

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

» 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 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 Networks

**PEHP Advantage**

The PEHP Advantage network of providers consists of predominantly Intermountain Healthcare (IHC) providers and facilities. It includes 34 participating hospitals and more than 7,500 participating providers.

**PARTICIPATING HOSPITALS**

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital

Cache County
- Logan Regional Hospital

Carbon County
- Castleview Hospital

Davis County
- Davis Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Cedar City Hospital

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Hospital
- Fillmore Community Hospital

Salt Lake County
- Alta View Hospital
- Intermountain Medical Center

Salt Lake County (cont.)
- The Orthopedic Specialty Hospital (TOSH)
- LDS Hospital
- Primary Children’s Medical Center
- Riverton Hospital

San Juan County
- Blue Mountain Hospital
- San Juan Hospital

Sanpete County
- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County
- Sevier Valley Hospital

Summit County
- Park City Medical Center

Tooele County
- Mountain West Medical Center

Uintah County
- Ashley Valley Medical Center

Utah County
- American Fork Hospital
- Orem Community Hospital
- Utah Valley Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- McKay Dee Hospital

**PEHP Summit**

The PEHP Summit network of providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 39 participating hospitals and more than 7,500 participating providers.

**PARTICIPATING HOSPITALS**

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital
- Brigham City Community Hospital

Cache County
- Cache Valley Specialty

Carbon County
- Carbon Valley Hospital

Davis County
- Davis Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Cedar City Hospital

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Hospital
- Fillmore Community Hospital

Salt Lake County
- Huntsman Cancer Hospital
- Jordan Valley Hospital
- Jordan Valley Hospital - West

Salt Lake County (cont.)
- Lone Peak Hospital
- Primary Children’s Medical Center
- Primary Children’s Hospital - Riverton
- St. Mark’s Hospital
- Salt Lake Regional Medical Center
- University of Utah Hospital
- University Orthopaedic Center

San Juan County
- Blue Mountain Hospital
- San Juan Hospital

Sanpete County
- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County
- Sevier Valley Hospital

Summit County
- Park City Medical Center

Tooele County
- Mountain West Medical Center

Uintah County
- Ashley Valley Medical Center

Utah County
- Mountain View Hospital
- Timpanogos Regional Hospital
- Mountain Point Medical Center

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- Ogden Regional Medical Center

**PEHP Preferred**

The PEHP Preferred network of providers consists of providers and facilities in both the Advantage and Summit networks. It includes 46 participating hospitals and more than 12,000 participating providers.

**Find Participating Providers**

Go to www.pehp.org to look up participating providers for each plan.
### Medical Benefits: Traditional

#### Summit, Advantage & Preferred

**Medical Benefits: Traditional**

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

<table>
<thead>
<tr>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</strong></td>
</tr>
<tr>
<td><strong>Plan Year Deductible</strong></td>
</tr>
<tr>
<td>Not included in the Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>$350 per individual, $700 per family</strong></td>
</tr>
<tr>
<td><strong>Plan year Out-of-Pocket Maximum</strong></td>
</tr>
<tr>
<td><strong>$3,000 per individual, $6,000 per double, $9,000 per family</strong></td>
</tr>
</tbody>
</table>

#### In-Network Provider

- **Medical and Surgical** | All out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details
- **Skilled Nursing Facility** | Non-custodial
  - Up to 60 days per plan year. Requires preauthorization
- **Hospice** | Up to 6 months in a 3-year period
  - Requires preauthorization
- **Rehabilitation** | Up to 45 days per plan year. Requires preauthorization
- **Mental Health and Substance Abuse** |
  - Requires preauthorization

#### Out-of-Network Provider

<table>
<thead>
<tr>
<th><strong>In-Network Provider</strong></th>
<th><strong>Out-of-Network Provider</strong></th>
</tr>
</thead>
</table>
| **Medical and Surgical** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |
| **Skilled Nursing Facility** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |
| **Hospice** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |
| **Rehabilitation** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |
| **Mental Health and Substance Abuse** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |

#### Outpatient Facility Services

<table>
<thead>
<tr>
<th><strong>In-Network Provider</strong></th>
<th><strong>Out-of-Network Provider</strong></th>
</tr>
</thead>
</table>
| **Outpatient Facility and Ambulatory Surgery** | 20% of In-Network Rate after deductible 
  - 40% of In-Network Rate after deductible |
| **Ambulance (ground or air)** | 20% of In-Network Rate after deductible 
  - 20% of In-Network Rate after deductible |
| **Emergency Room** | 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** |
  - Preferred only:
    - University of Utah Medical Group Urgent Care Facility: $50 co-pay per visit
  - 40% of In-Network Rate after deductible 
  - Preferred only:
    - Not applicable |
| **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
  - 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: Traditional

## Professional Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Physician Visits</strong></td>
<td>Applicable office co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td><strong>Surgery and Anesthesia</strong></td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td><strong>PEHP e-Care</strong></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><strong>PEHP Value Clinics</strong></td>
<td>Medical: $10 co-pay per visit</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Primary Care Office Visits and Office Surgeries</strong></td>
<td>$25 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td><strong>Specialist Office Visits and Office Surgeries</strong></td>
<td>$35 co-pay per visit</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Specialist</strong></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><strong>Diagnostic Tests, X-rays</strong></td>
<td>20% of In-Network Rate after deductible</td>
<td>40% of In-Network Rate after deductible</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong></td>
<td>Outpatient: $35 co-pay per visit Inpatient: Applicable office co-pay per visit</td>
<td>Outpatient: 40% of In-Network Rate after deductible Inpatient: 40% of In-Network Rate after deductible</td>
</tr>
</tbody>
</table>

## Prescription Drugs

<table>
<thead>
<tr>
<th>Type of Pharmacy</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Plan Pays</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day Pharmacy</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>Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance</td>
<td></td>
</tr>
<tr>
<td>90-day Pharmacy</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>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, retail pharmacy</td>
<td>20%</td>
<td>30%</td>
<td>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</td>
<td>20% of In-Network Rate after deductible. No maximum co-pay</td>
<td>30% of In-Network Rate after deductible. No maximum co-pay</td>
<td>40% of In-Network Rate after deductible. 50% of In-Network Rate after deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, through specialty vendor Accredo</td>
<td>20%, $150 maximum co-pay</td>
<td>30%, $225 maximum co-pay</td>
<td>20%, No maximum co-pay</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>MISCELLANEOUS SERVICES</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption</td>
<td>See limitations</td>
<td>No charge after deductible, up to $4,000 per adoption</td>
<td></td>
<td></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>
<td></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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Applicable office co-pay per visit</td>
<td>Not covered</td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></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>
<td></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>
<td></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>
<td></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>
<td></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>
<td></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>
<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.
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 $2,550 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


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 Value Clinics

**Convenient and Affordable** 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.

**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 | 801-441-1002

**NORTH SALT LAKE**
Orbit Employee Clinic
845 Overland St. | 801-951-5888

FJM Clinic
31 N Redwood Rd, Suite 2 | 801-624-1634

**CLEARFIELD**
Futura Onsite Clinic
11 H Street | 801-774-3265

**LAYTON**
Onsite Care at Davis Hospital
1580 W. Antelope Dr., Suite 110 | 801-807-7699

**OGDEN**
Health Clinics of Utah
2540 Washington Blvd., Ste. 122 | 801-626-3670

FJM Clinic
1104 Country Hills Dr., Ste. 110 | 801-624-1633

**PROVO**
Health Clinics of Utah
150 E Center St., Ste. 1100 | 801-374-7011

**OREM**
Blendtec Health and Wellness Clinic
1206 S 1680 W | 801-225-1281

**LEHI**
OnSite Care at Mountain Point Medical
3000 Triumph Blvd, Ste. 320 | 801-753-4600


Check with your employer to see which medical plans are available to you. You must be enrolled in an active PEHP medical plan to visit a medical clinic.
Amwell On-Demand Doctors

A Faster, Easier Way to See a Doctor  » See a doctor via mobile or web. It’s available 24 hours a day, every day, and you don’t need an appointment. Use Amwell for fevers, ear infections, cold, flu, allergies, migraines, pinkeye, stomach pain, and much more.

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 $40 before you meet your deductible. After your deductible is met, you pay only a $10 co-pay.

To Get PEHP’s Lower Pricing
1. Go to www.amwell.com or download the app (available at iTunes and Google Play Store).
2. Choose “PEHP” as your health insurance.
3. Enter your subscriber ID. Find it on your benefits card. Or log in to PEHP for Members and go to “See What I’m Enrolled In” in the “my Benefits” menu.
4. Find the service key field and enter “PEHP” if you’re on the Traditional Plan or “PEHPSTAR” if you’re on The STAR Plan.
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.

Understanding The PEHP STAR Plan

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 Expenses

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.

Enroll 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 with 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.

Remember the funds in this account are use or lose. The maximum you can deposit is $2,600 for the plan year. Remember as an enrollee in The STAR Plan, you are also enrolled in the Health Savings Account (HSA).
**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>
<tbody>
<tr>
<td>Employee semi-monthly cost for medical benefits</td>
<td>$0</td>
<td>Individual: $27.21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Double: $56.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family: $74.88</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Rates for Summit &amp; Advantage plans only)</td>
</tr>
<tr>
<td>WSU semi-monthly Contribution</td>
<td>Semi-monthly: Single: $33.09 Double: $66.18 Family: $66.18</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Out-of-pocket Maximum</td>
<td>Medical &amp; RX: Single: $2,500 Double: $5,000 Family: $7,500</td>
<td>Medical &amp; RX: Single: $3,000 Double: $6,000 Family: $9,000</td>
</tr>
</tbody>
</table>

**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.
### Medical Benefits: STAR

#### STAR Plan (HSA-Qualified)

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

#### INPATIENT FACILITY SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Rate</th>
<th>Out-of-Network Rate</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</th>
<th>In-Network Rate</th>
<th>Out-of-Network Rate</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%</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.
## Professional Services

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Surgery and Anesthesia</td>
<td>20% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>PEHP e-Care Amwell</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>
</tr>
<tr>
<td>PEHP Value Clinics</td>
<td>Medical: 20% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Primary Care Office Visits and Office Surgeries</td>
<td>20% 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>
</tr>
<tr>
<td>Emergency Room Specialist</td>
<td>20% of In-Network Rate after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays</td>
<td>20% 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 Inpatient: 20% of In-Network Rate after deductible</td>
</tr>
</tbody>
</table>

## Prescription Drugs

### All pharmacy benefits for The STAR Plan are subject to the deductible

<table>
<thead>
<tr>
<th>Prescriptions Type</th>
<th>Tier A</th>
<th>Tier B</th>
<th>Tier C</th>
<th>Tier D</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day Pharmacy Retail only</td>
<td>$10 co-pay</td>
<td>25% of discounted cost.</td>
<td>50% of discounted cost.</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance</td>
</tr>
<tr>
<td>90-day Pharmacy Maintenance only</td>
<td>$20 co-pay</td>
<td>25% of discounted cost.</td>
<td>50% of discounted cost.</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance</td>
</tr>
<tr>
<td>Specialty Medications, retail pharmacy Up to 30-day supply</td>
<td>20%</td>
<td>30%</td>
<td>Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, office/outpatient Up to 30-day supply</td>
<td>20% of In-Network Rate. No maximum co-pay</td>
<td>30% of In-Network Rate. No maximum co-pay</td>
<td>Tier A: 40% of In-Network Rate. Tier B: 50% of In-Network Rate.</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications, through specialty vendor Accredo Up to 30-day supply</td>
<td>20%, $150 maximum co-pay</td>
<td>30%, $225 maximum co-pay</td>
<td>20%. No maximum co-pay</td>
<td>Not covered</td>
</tr>
<tr>
<td>MISCELLANEOUS SERVICES</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption</td>
<td>No charge after deductible, up to $4,000 per adoption</td>
<td>40% of In-Network Rate after deductible</td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>See Master Policy for complete list</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>20% of In-Network Rate after deductible</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 10 visits per plan year</td>
<td></td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></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>
<td></td>
<td></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>40% of In-Network Rate after deductible</td>
<td></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>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 60 visits per plan year. Requires preauthorization</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>Select services only. See the Master Policy</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires preauthorization if over $750</td>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to $1,000 lifetime maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
- Conscious (moderate) Sedation, a type of anesthesia, along with Monitored Anesthesia Care (MAC), is included in standard colonoscopy and is not reimbursed separately, as it’s included in the payment to the rendering Physician. General Anesthesia or MAC done by any Provider other than the rendering Physician must be Medically Necessary and requires Preauthorization through PEHP.
- 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 women ages 21-65.

Continued on back
Preventive Benefits

Continued from front

» Chlamydia infection screening for younger women and other women at higher risk.
» Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
» Covered services/devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphragms, cervical caps, emergency contraceptives (Elfa, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
» Domestic and interpersonal violence screening and counseling for all women.
» Folic acid supplements for women who may become pregnant, covered under the pharmacy benefit when prescribed by a physician.
» Gestational diabetes screening for women 24 to 28 weeks pregnant and those at higher risk of developing gestational diabetes.
» Gonorrhea screening for all women at higher risk.
» Gonorrhea screening for all women at higher risk.
» Hepatitis B screening for pregnant women at their first prenatal visit.
» Human immunodeficiency virus (HIV) screening and counseling for sexually active women.
» Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older in conjunction with cervical cancer screening (pap smear).
» Osteoporosis screening for women over age 60 depending on risk factors.
» Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
» Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
» Sexually transmitted infections (STI): counseling for sexually active women.
» Syphilis screening for all pregnant women or other women at increased risk.

Covered Preventive Services Specifically for Children
(Younger than age 18)

» Preventive physical exam visits throughout childhood as recommended by the American Academy of Pediatrics including:
  » 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.
» Phenyketonuria (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 Raloxifene.
» 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.
» Phenylketonurea test.
» Prostate cancer screening.
» PSA (prostate specific antigen) screening.
» Refraction exams.
» Blood typing for pregnant women.
» Rubella screening for all women of childbearing age at their first clinical encounter.

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

* 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.

1. **AMOUNT CHARGED**
The medical provider’s (e.g., doctor, hospital, or clinic) bill for your service.

2. **AMOUNT INELIGIBLE**
The part of the bill that includes services not covered by your plan. This is between you and the provider.

3. **AMOUNT ELIGIBLE**
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 www.pehp.org).

4. **DEDUCTIBLE**
The set amount you pay for eligible charges in a plan year before cost sharing takes place.

5. **CO-INSURANCE**
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.

6. **CO-PAY**
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.

7. **AMOUNT PAID**
The part of the bill PEHP paid.

8. **CLAIM NUMBER**
Keep this number as reference if you call PEHP about your claim.

9. **YOUR TOTAL RESPONSIBILITY**
The amount of the bill the provider expects you to pay. This is between you and the provider.

10. **CPT CODE**
This code for the service you received can be helpful when discussing your EOB with your doctor or PEHP.