

# Benefits Summary

2018-19

Piute School District

Look inside for important information about how to use your PEHP benefits.



**PEHP**  
Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES





# Piute School District

## 2018-19

### Piute School District Benefits Summary

#### **UTAH SCHOOL BOARDS ASSOCIATION**

Benefits Summary

Effective September 2018

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This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP subscribers who are employed by Piute School District employers and their eligible dependents. Members of any other PEHP plan should refer to the applicable publications for their coverage.

It is important to familiarize yourself with the information provided in this Benefits Summary and the PEHP Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP. You may also view it at [www.pehp.org](http://www.pehp.org).

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP.

The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at [www.pehp.org](http://www.pehp.org). All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

The information in this Benefits Summary is distributed on an "as is" basis, without warranty. While every precaution has been taken in the preparation of this Benefits Summary, PEHP shall not incur any liability due to loss, or damage caused or alleged to be caused, directly or indirectly by the information contained in this Benefits Summary.

The information in this Benefits Summary is intended as a service to members of PEHP. While this information may be copied and used for your personal benefit, it is not to be used for commercial gain.

The employers participating with PEHP are not agents of PEHP and do not have the authority to represent or bind PEHP.

7-26-18

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# Welcome to PEHP

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**

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

Create a PEHP for Members account at [www.pehp.org](http://www.pehp.org) to review your claims history, get important information through our Message Center, see a comprehensive list of your coverages, find and compare providers in your network, access Healthy Utah rebate information, check your FLEX\$ account balance, and more.

**CUSTOMER SERVICE/  
HEALTH BENEFITS ADVISORS**

..... 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 Preauthorization..... 801-366-7755  
..... or 800-753-7754

**PRESCRIPTION DRUG BENEFITS**

» PEHP Pharmacy ..... 801-366-7551  
..... or 888-366-7551

**SPECIALTY PHARMACY**

» Accredo ..... 800-501-7260

**HEALTH SAVINGS ACCOUNTS (HSA)**

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

**WELLNESS AND DISEASE MANAGEMENT**

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

» PEHP Health Coaching ..... 801-366-7300  
..... or 855-366-7300

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

» PEHP Integrated Care (Ask for Member Services Nurse)  
..... 801-366-7555  
..... or 800-765-7347

**VALUE-ADDED BENEFITS**

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

**ONLINE ENROLLMENT HELP LINE**

..... 801-366-7410  
..... or 800-753-7410

**CLAIMS MAILING ADDRESS**

PEHP  
560 East 200 South  
Salt Lake City, Utah 84102-2004

# Find More at [www.pehp.org](http://www.pehp.org)

## PEHP Value Clinics

**Convenient and Affordable** » These full-service clinics provide all the services of a family doctor or dentist, but at a lower cost. [Learn More](#)

## Connect Care

**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 Intermountain Connect Care for fevers, ear infections, cold, flu, allergies, migraines, pinkeye, stomach pain, and much more. [Learn More](#)

## Your Network and Your Money

**Get the Most out of Your Healthcare Dollars** » Get the best benefit by visiting doctors, hospitals, and other providers contracted in your network. Otherwise, you could be on the hook for unnecessary large bills. [Learn More](#)

## Know Before You Go

**Four Simple Steps** » As healthcare gets costlier and more complex, carefully consider where and how you get care to maximize your PEHP benefits. "Know Before You Go" — that means taking a few simple steps beforehand to assure you get the right care, at the best value, and avoid the nasty surprise of an unnecessary large bill. [Learn More](#)

## Out-of-Network Benefits

**Know Your Network** » Some PEHP plans pay benefits for out-of-network providers. However, PEHP doesn't pay for any services from certain providers, regardless if you have an out-of network benefit. [Learn More](#)

## Find a Provider

Looking for a provider, clinic, or facility that is contracted with your plan? Look no farther than [www.pehp.org](http://www.pehp.org). Log in to PEHP for Members to search for providers by name, specialty, or location.

Click [here](#) for a list of hospitals in your medical network.

# Understanding In-Network Providers

It's important to understand the difference between in-network and out-of-network providers and how the In-Network Rate works to avoid unexpected charges.

## In-Network Rate

Doctors and facilities contracted in your network — in-network providers — have agreed not to charge more than PEHP's In-Network Rate for specific services. Your benefits are often described as a percentage of the In-Network Rate. With in-network providers, you pay a predictable amount of the bill: the remaining percentage of the In-Network Rate. For example, if PEHP pays your benefit at 80% of In-Network Rate, your portion of the bill generally won't exceed 20% of the In-Network Rate.

## Balance Billing

It's a different story with out-of-network providers. They may charge more than the In-Network Rate unless they have an agreement with you not to. These doctors and facilities, who aren't a part of your network, have no pricing agreement with PEHP. The portion of the benefit PEHP pays is based on what we would pay a n in-network provider. You'll be billed the full amount that the provider charges above the In-Network Rate. This is called "balance billing."

Understand that charges to you may be substantial if you see an out-of-network provider. Your plan generally pays a smaller percentage of the In-Network Rate, and you'll also be billed for any amount charged above the In-Network Rate.

## Negotiate a Price

**Don't get Balance Billed:** Although non-contracted providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

The amount you pay for charges above the In-Network Rate won't apply to your deductible or out-of-pocket maximum.

## Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the Medical Networks comparison in this book or go to [www.pehp.org](http://www.pehp.org) and log in to PEHP for Members to see which network includes your doctors.

Ask questions before you get medical care. Make sure every person and every facility involved is contracted in your network.

Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

[Learn More » Your Network and Your Money](#)



Go to [www.pehp.org](http://www.pehp.org), log into PEHP for Members, and click on *Find and Select a Provider* under the *myBenefits* menu to find a doctor or facility in your network.

# Understanding Your Benefits Grid

	Out-of-Network	In-Network
<b>Plan year Deductible</b> <i>Does not apply to out-of-pocket maximum</i>		\$250 per individual
<b>Plan year Out-of-Pocket Maximum**</b>		\$2,000 per individual
<b>Mental Health and Substance Abuse Out-of-Pocket Limits</b> <i>Separate Yearly out-of-pocket maximum</i>		\$2,000 per individual, \$4,000 per family
<b>Specialty Drug Out-of-Pocket Maximum</b> <i>Separate Yearly out-of-pocket maximum</i>		\$3,600 per member, per year

**1 MEDICAL DEDUCTIBLE**  
The set dollar amount that you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

**2 PLAN YEAR OUT-OF-POCKET MAXIMUM**  
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for STAR plans). Some plans might also have separate out-of-pocket maximums for mental health & substance abuse and for specialty drug charges.

**CO-PAY**

A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP In-Network Rate.

**IN-NETWORK**

In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay the applicable copayment.

**OUT-OF-NETWORK**

If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP's In-Network Rate.

**IN-NETWORK RATE**

The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the In-Network Rate (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

*For more definitions, please see the Master Policy.*





**MEDICAL BENEFITS GRID: WHAT YOU PAY**

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

Preferred	In-Network Provider	Out-of-Network Provider
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	None	\$500 per individual, \$1,000 per family
<b>Plan year Out-of-Pocket Maximum*</b>	\$3,500 per individual, \$7,000 per family	\$7,500 per individual, \$15,000 per family
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical and Surgical</b>   <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	10% of In-Network Rate after \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Skilled Nursing Facility</b>   <i>Non-custodial Up to 60 days per plan year. Requires preauthorization</i>	10% of In-Network Rate after \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Hospice</b>   <i>Up to 6 months in a 3-year period. Requires preauthorization</i>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Rehabilitation</b>   <i>Up to 45 days per plan year. Requires preauthorization</i>	10% of In-Network Rate after \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization</i>	20% of In-Network Rate	40% of In-Network Rate after Deductible
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgery</b>	10% of In-Network Rate after \$250 Copayment	40% of In-Network Rate after Deductible and \$250 Copayment per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	10% of In-Network Rate	
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	10% of In-Network Rate after \$150 Copayment	10% of In-Network Rate after \$150 Copayment, plus any balance billing above In-Network Rate
<b>Urgent Care Facility</b>	\$30 Copayment per visit	40% of In-Network Rate after Deductible
<b>Diagnostic Tests, X-rays</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Chemotherapy, Radiation, and Dialysis</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible. Dialysis requires preauthorization
<b>Physical and Occupational Therapy</b> <i>Outpatient - Up to 20 combined visits per plan year. No Preauthorization required.</i>	Applicable Copayment per visit	40% of In-Network Rate after Deductible

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

\*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

Piute School District 2018-19 » Medical Benefits Grid » Gold Plan

	In-Network Provider	Out-of-Network Provider
<b>PROFESSIONAL SERVICES</b>		
<b>Inpatient Physician Visits</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Surgery and Anesthesia</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit. <b>Mental Health:</b> Standard benefits apply	Not applicable
<b>PEHP Value Clinics</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Office Visits</b> <i>Includes office surgeries</i>	\$20 Copayment per visit	40% of In-Network Rate after Deductible
<b>Specialist Office Visits</b> <i>Includes office surgeries</i>	\$40 Copayment per visit	40% of In-Network Rate after Deductible
<b>Emergency Room Specialist Visits</b>	10% of In-Network Rate	10% of In-Network Rate, plus any balance billing above In-Network Rate
<b>University of Utah Medical Group Office Visits</b> <i>Preferred plan only. Includes office surgeries</i>	\$40 Copayment per visit	Not applicable
<b>Diagnostic Tests, X-rays</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Mental Health/Substance Abuse</b> <i>No Preauthorization for outpatient services. Inpatient services require Preauthorization</i>	<b>Inpatient:</b> 20% of In-Network Rate <b>Outpatient:</b> 20% of In-Network Rate, up to 20 visits per plan year	<b>Inpatient:</b> 40% of In-Network Rate after Deductible <b>Outpatient:</b> 40% of In-Network Rate after Deductible, up to 20 visits per plan year
<b>PRESCRIPTION DRUGS</b>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$15 Copayment <b>Tier 2:</b> 25% of discounted cost. \$30 minimum, \$90 maximum Copayment <b>Tier 3:</b> 50% of discounted cost. \$55 minimum, \$200 maximum Copayment	Plan pays up to discounted cost, minus the applicable copayment. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$25 Copayment <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, \$150 maximum Copayment <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, \$200 maximum Copayment	Not covered
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum Copayment <b>Tier B:</b> 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% of In-Network Rate. No maximum Copayment <b>Tier B:</b> 30% of In-Network Rate. No maximum Copayment	<b>Tier A:</b> 40% of In-Network Rate after Deductible. No maximum co-pay <b>Tier B:</b> 50% of In-Network Rate after Deductible. No maximum co-pay
<b>Specialty Medications, through specialty vendor Accredo</b>   <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum Copayment <b>Tier B:</b> 30%. \$225 maximum Copayment <b>Tier C:</b> 20%. No maximum Copayment	Not covered

Piute School District 2018-19 » Medical Benefits Grid » Gold Plan

	In-Network Provider	Out-of-Network Provider
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Limitations</i>	10% up to \$4,000 per adoption	
<b>Allergy Serum</b>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Chiropractic Care</b>   <i>Up to 20 visits per plan year</i>	\$40 Copayment per visit	Not covered
<b>Durable Medical Equipment, DME</b> <i>Except for oxygen and Sleep Disorder Equipment, certain DME over \$750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits</i>	20% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Medical Supplies</b> <i>See the Master Policy for benefit limits</i>	20% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Hearing Aids</b> <i>Requires Preauthorization</i>	20% of In-Network Rate, up to one pair of hearing aids every three years	Not covered
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	10% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Infertility Services*</b>   <i>Select services only. See Master Policy. Up to \$1,500 per plan year. \$5,000 Lifetime Maximum</i>	50% of In-Network Rate	50% of In-Network Rate after Deductible
<b>Injections</b>	<b>Under \$50:</b> No charge <b>Over \$50:</b> 20% of In-Network Rate	40% of In-Network Rate after Deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical</i>	Not covered	Not covered
<b>Dental Accident Benefit</b>	10% of In-Network Rate. See Limitations	10% of In-Network Rate plus any balance billing above In-Network Rate. See Limitations
<b>WELLCARE PROGRAM   ANNUAL ROUTINE CARE</b>		
<b>Affordable Care Act Preventive Services</b>	No charge	Not covered
<b>Routine Vision Exams</b> <i>1 visit per year</i>	Applicable office Copayment per visit	Not covered
<b>Routine Hearing Exams</b> <i>1 visit per year</i>	Applicable office Copayment per visit	Not covered
<b>Diabetes Education</b> <i>Must be for the diagnosis of diabetes</i>	One occurrence per plan year	No charge plus any balance billing above In-Network Rate, one occurrence per plan year



**MEDICAL BENEFITS GRID: WHAT YOU PAY**

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

Preferred	In-Network Provider	Out-of-Network Provider
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	\$200 per individual, \$600 per family	\$500 per individual, \$1,000 per family
<b>Plan year Out-of-Pocket Maximum*</b>	\$4,500 per individual, \$9,200 per family	\$8,500 per individual, \$17,000 per family
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical and Surgical</b>   <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	20% of In-Network Rate after Deductible and \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Skilled Nursing Facility</b>   <i>Non-custodial Up to 60 days per plan year. Requires preauthorization</i>	20% of In-Network Rate after Deductible and \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Hospice</b>   <i>Up to 6 months in a 3-year period. Requires preauthorization</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Rehabilitation</b>   <i>Up to 45 days per plan year. Requires preauthorization</i>	20% of In-Network Rate after Deductible and \$500 Copayment	40% of In-Network Rate after Deductible and \$500 Copayment
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgery</b>	20% of In-Network Rate after Deductible and \$250 Copayment	40% of In-Network Rate after Deductible and \$250 Copayment
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% of In-Network Rate after Deductible	
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% of In-Network Rate after Deductible and \$150 Copayment	20% of In-Network Rate after Deductible and \$150 Copayment, plus any balance billing above In-Network Rate
<b>Urgent Care Facility</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Diagnostic Tests, X-rays</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Chemotherapy, Radiation, and Dialysis</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible. Dialysis requires preauthorization
<b>Physical and Occupational Therapy</b> <i>Outpatient - Up to 20 combined visits per plan year. No Preauthorization required.</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

\*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

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	In-Network Provider	Out-of-Network Provider
<b>PROFESSIONAL SERVICES</b>		
<b>Inpatient Physician Visits</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Surgery and Anesthesia</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit. <b>Mental Health:</b> Standard benefits apply	Not applicable
<b>PEHP Value Clinics</b>	\$10 co-pay per visit	Not applicable
<b>Primary Care Office Visits</b> <i>Includes office surgeries</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Specialist Office Visits</b> <i>Includes office surgeries</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Emergency Room Specialist Visits</b>	20% of In-Network Rate	20% of In-Network Rate plus any balance billing above In-Network Rate
<b>Diagnostic Tests, X-rays</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Mental Health/Substance Abuse</b> <i>No Preauthorization for outpatient services. Inpatient services require Preauthorization</i>	<b>Inpatient:</b> 20% of In-Network Rate after Deductible <b>Outpatient:</b> 20% of In-Network Rate after Deductible, up to 20 visits per plan year	<b>Inpatient:</b> 40% of In-Network Rate after Deductible <b>Outpatient:</b> 40% of In-Network Rate after Deductible, up to 20 visits per plan year
<b>PRESCRIPTION DRUGS</b>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$15 Copayment <b>Tier 2:</b> 25% of discounted cost. \$30 minimum, \$90 maximum Copayment <b>Tier 3:</b> 50% of discounted cost. \$55 minimum, \$200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$25 Copayment <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, \$150 maximum Copayment <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, \$200 maximum Copayment	Not covered
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum Copayment <b>Tier B:</b> 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% of In-Network Rate after Deductible. No maximum Copayment <b>Tier B:</b> 30% of In-Network Rate after Deductible. No maximum Copayment	<b>Tier A:</b> 40% of In-Network Rate after Deductible. No maximum co-pay <b>Tier B:</b> 50% of In-Network Rate after Deductible. No maximum co-pay
<b>Specialty Medications, through specialty vendor Accredo</b>   <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum Copayment <b>Tier B:</b> 30%. \$225 maximum Copayment <b>Tier C:</b> 20%. No maximum Copayment	Not covered

**Piute School District 2018-19 » Medical Benefits Grid » Silver Plan**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider</b>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Limitations</i>	20% after In-Network Deductible up to \$4,000 per adoption	
<b>Allergy Serum</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Chiropractic Care</b>   <i>Up to 20 visits per plan year</i>	20% of In-Network Rate after Deductible	Not covered
<b>Durable Medical Equipment, DME</b> <i>Except for oxygen and Sleep Disorder Equipment, certain DME over \$750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Medical Supplies</b> <i>See the Master Policy for benefit limits</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Hearing Aids</b> <i>Requires Preauthorization</i>	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Infertility Services*</b>   <i>Select services only. See Master Policy. Up to \$1,500 per plan year. \$5,000 Lifetime Maximum</i>	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Injections</b>	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical</i>	Not covered	Not covered
<b>Dental Accident Benefit</b>	20% of In-Network Rate after Deductible. See Limitations	20% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations
<b>WELLCARE PROGRAM   ANNUAL ROUTINE CARE</b>		
<b>Affordable Care Act Preventive Services</b>	No charge	Not covered
<b>Routine Vision Exams</b> <i>1 visit per year</i>	No charge	No charge plus any balance billing above In-Network Rate
<b>Routine Hearing Exams</b> <i>1 visit per year</i>	Not covered	Not covered
<b>Diabetes Education</b> <i>Must be for the diagnosis of diabetes</i>	One occurrence per plan year	No charge plus any balance billing above In-Network Rate, one occurrence per plan year



**MEDICAL BENEFITS GRID: WHAT YOU PAY**

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

Preferred	In-Network Provider	Out-of-Network Provider
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	\$1,750 per single, \$3,500 per family	
<b>Plan year Out-of-Pocket Maximum*</b>	\$3,500 per single, \$7,000 per family	
<b>INPATIENT FACILITY SERVICES</b>		
<b>Medical and Surgical</b>   <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Skilled Nursing Facility</b>   <i>Non-custodial Up to 60 days per plan year. Requires preauthorization</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Hospice</b>   <i>Up to 6 months in a 3-year period. Requires preauthorization</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Rehabilitation</b>   <i>Up to 45 days per plan year. Requires preauthorization</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Mental Health and Substance Abuse</b> <i>Requires preauthorization</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgery</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	25% of In-Network Rate after Deductible	
<b>Emergency Room</b> <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	25% of In-Network Rate after Deductible	25% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
<b>Urgent Care Facility</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Diagnostic Tests, X-rays</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Chemotherapy, Radiation, and Dialysis</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible. Dialysis requires preauthorization
<b>Physical and Occupational Therapy</b> <i>Outpatient - Up to 20 combined visits per plan year. No Preauthorization required.</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible

In- and Out-of-Network deductible and Out-of-Pocket Maximums are combined and do not accumulate separately.

\*Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

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	In-Network Provider	Out-of-Network Provider
<b>PROFESSIONAL SERVICES</b>		
<b>Inpatient Physician Visits</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Surgery and Anesthesia</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>PEHP e-Care</b>	<b>Medical:</b> \$10 co-pay per visit after Deductible. <b>Mental Health:</b> Standard benefits apply after Deductible	Not applicable
<b>PEHP Value Clinics</b>	<b>Medical:</b> 25% of In-Network Rate after Deductible	Not applicable
<b>Primary Care Office Visits</b> <i>Includes office surgeries</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Specialist Office Visits</b> <i>Includes office surgeries</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Emergency Room Specialist Visits</b>	25% of In-Network Rate after Deductible	25% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
<b>Diagnostic Tests, X-rays</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Mental Health/Substance Abuse</b> <i>No Preauthorization for outpatient services. Inpatient services require Preauthorization</i>	<b>Inpatient:</b> 25% of In-Network Rate after Deductible <b>Outpatient:</b> 25% of In-Network Rate after Deductible, up to 20 visits per plan year	<b>Inpatient:</b> 50% of In-Network Rate after Deductible <b>Outpatient:</b> 50% of In-Network Rate after Deductible, up to 20 visits per plan year
<b>PRESCRIPTION DRUGS</b> <i>All pharmacy benefits for HSA plans are subject to the Deductible</i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> 25% of discounted cost <b>Tier 2:</b> 25% of discounted cost <b>Tier 3:</b> 35% of discounted cost	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> 25% of discounted cost <b>Tier 2:</b> 25% of discounted cost <b>Tier 3:</b> 35% of discounted cost	Not covered
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 25%. No maximum Copayment <b>Tier B:</b> 30%. No maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 25% of In-Network Rate. No maximum Copayment <b>Tier B:</b> 30% of In-Network Rate. No maximum Copayment	<b>Tier A:</b> 45% of In-Network Rate. No maximum co-pay <b>Tier B:</b> 50% of In-Network Rate. No maximum co-pay
<b>Specialty Medications, through specialty vendor Accredo</b>   <i>Up to 30-day supply</i>	<b>Tier A:</b> 25%. \$150 maximum Copayment <b>Tier B:</b> 30%. \$225 maximum Copayment <b>Tier C:</b> 20%. No maximum Copayment	Not covered



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	<b>In-Network Provider</b>	<b>Out-of-Network Provider</b>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>   <i>See Limitations</i>	25% after Deductible up to \$4,000 per adoption	
<b>Allergy Serum</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Chiropractic Care</b>   <i>Up to 20 visits per plan year</i>	25% of In-Network Rate after Deductible	Not covered
<b>Durable Medical Equipment, DME</b> <i>Except for oxygen and Sleep Disorder Equipment, certain DME over \$750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Medical Supplies</b> <i>See the Master Policy for benefit limits</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Hearing Aids</b> <i>Requires Preauthorization</i>	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy. Up to \$1,500 per plan year. \$5,000 Lifetime Maximum</i>	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Injections</b>	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical</i>	Not covered	Not covered
<b>Dental Accident Benefit</b>	25% of In-Network Rate after Deductible. See Limitations	25% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. See Limitations
<b>WELLCARE PROGRAM   ANNUAL ROUTINE CARE</b>		
<b>Affordable Care Act Preventive Services</b>	No charge	Not covered
<b>Routine Vision Exams</b> <i>1 visit per year</i>	No charge	Not covered
<b>Routine Hearing Exams</b> <i>1 visit per year</i>	Not covered	Not covered
<b>Diabetes Education</b> <i>Must be for the diagnosis of diabetes</i>	One occurrence per plan year	No charge plus any balance billing above In-Network Rate, one occurrence per plan year

# Wellness and Value-Added Benefits

## PEHP Healthy Utah

PEHP Healthy Utah is an employee health promotion program aimed at enhancing the well-being of members by increasing awareness of health risks and providing support in making health-related lifestyle changes. PEHP Healthy Utah offers a variety of programs, services, cash incentives, and resources to help members get and stay well.

Subscribers and their spouses are eligible to attend one Healthy Utah biometric testing session each plan year free of charge. PEHP Healthy Utah is offered at the discretion of the Employer.

### FOR MORE INFORMATION

PEHP Healthy Utah

801-366-7300 or 855-366-7300

» Email: [healthyutah@pehp.org](mailto:healthyutah@pehp.org)

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

## PEHP WeeCare

PEHP WeeCare is a pregnancy and postpartum program provided to support and educate PEHP members. PEHP WeeCare's goal is to help expectant mothers have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy up to 12 months after delivery.

Participate in PEHP WeeCare and you may qualify for free prenatal vitamins, books and educational resources. Cash incentives are available for enrolling and for postpartum weight loss. While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

### FOR MORE INFORMATION

PEHP WeeCare

P.O. Box 3503

Salt Lake City, Utah 84110-3503

801-366-7400 | 855-366-7400

» E-mail: [weecare@pehp.org](mailto:weecare@pehp.org)

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

*\*FICA tax may be withheld from all wellness rebates. This will slightly lower any amount you receive. PEHP will mail additional tax information to you after you receive your rebate. Consult your tax advisor if you have any questions.*

## PEHP Health Coaching

PEHP Health Coaching is a lifestyle behavior change program available to subscribers and spouses with a body mass index (BMI) of 30 or greater. This benefit provides education, support, and rebates to help members engage in improving their health by forming action plans, setting goals, and following up monthly with a health coach.

Rebates are paid based on completing participation requirements rather than on weight loss. Enrolled members will work with a coach for 6-12\* months, with the opportunity to receive a \$50 rebate at the end of each 6-month interval.

The program is designed to help members achieve a healthy weight by learning how to form and sustain healthy habits. With this approach, members' focus can go beyond weight loss to the greater benefits of lasting health and well-being.

Interested members can enroll by logging on to [www.pehp.org](http://www.pehp.org), then selecting *My Health* › *PEHP Wellness* › *PEHP Health Coaching*.

*\*Length of enrollment and participation requirements will depend on a member's initial BMI.*

### FOR MORE INFORMATION

PEHP Health Coaching

801-366-7300 | 855-366-7300

» E-mail: [healthcoaching@pehp.org](mailto:healthcoaching@pehp.org)

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

If you are unable to meet the medical standards to qualify for the program because it is medically inadvisable or unreasonably difficult due to a medical condition, upon written notification, PEHP shall provide you with a reasonable alternative standard to qualify for the program. The total amount of rewards cannot be more than 30% of the cost of employee-only coverage under the plan.

## PEHP Plus

PEHPplus provides savings of up to 60 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts, so check it out at [www.pehp.org/plus](http://www.pehp.org/plus).



# myWellness Tracker



**myWellness Tracker** is an all-new wellness tracking program for you and your PEHP-insured spouse. The goal of the program is to help you create or sustain healthy habits - and get rewarded for it!

## How does it work?

myWellness Tracker, based on the WellRight digital platform, is used to create fun and engaging health and wellness challenges. It helps you stay motivated and improve your overall wellbeing. Sync your wearable device or manually track challenges within myWellness Tracker. Access the program portal either on your desktop or through the app.

Most challenges are 30 days, designed to create and track habits - such as your nutrition, exercise, or finances - over an entire month.

**myWellness Tracker is offered in addition to Healthy Utah, giving you an opportunity to “earn more.”**

## Rewards

### Earn Points - Get Cash

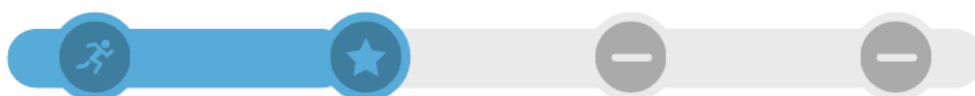
Points are awarded for completing challenges, helping you work towards three achievement levels. You earn \$50 for each level you reach - that's up to \$150 each plan year! PEHP sends you (the insured employee) a check at the end of the plan year for your accomplishments. FICA tax is withheld from all payments.

PEHP Wellness rebates are still available outside of myWellness Tracker:

- » Know & Plan
- » Good For You
- » BMI Improvement
- » Blood Pressure Improvement
- » Diabetes A & B Rebates
- » Cholesterol Improvement
- » Tobacco Cessation
- » Wee Care



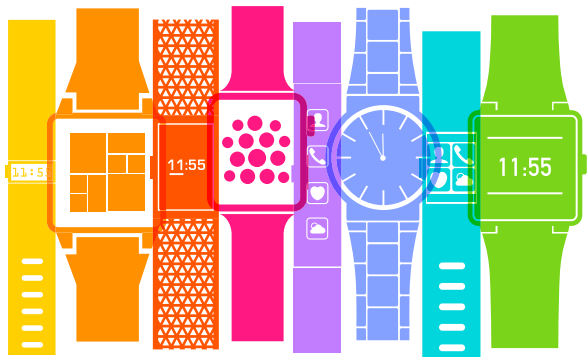
You have earned **1050** points!



# Program Features

## Device Integration

myWellness Tracker integrates easily with wearable tracking devices and apps, such as Apple Watch, FitBit, Garmin, and more. Don't have a wearable device? Download one of the compatible, FREE apps listed in the program portal. You can also manually track your progress within the myWellness Tracker portal.



## Other Features

- » **Biometric Data** - find your biometric data from Healthy Utah testing sessions in your Health Profile
- » **Message Board** - communicate with other users within a challenge
- » **Personal Calendar** - see your progress, challenge trackers, and more!
- » **Quick Links** - access PEHP products, services, and web pages easily with one menu

## How do I access myWellness Tracker?



PEHP will send you a registration link to myWellness Tracker via email and the Message Center. Follow the link to myWellness Tracker and get started!

## Text Tracking

Don't like the idea of manually tracking with your device? Text tracking is your solution! Each challenge has daily text reminders to help you form healthy habits. You can also track your results for a specific challenge by replying to the same reminder message.

## Download the App



Don't rely on a browser for all your tracking - download the WellRight app! The app has an easy-to-use interface and quick access to your challenges and progress.

TO REGISTER VISIT:  
**[usba.wellright.com](https://usba.wellright.com)**

# Disability Waiver

To the extent allowed under State Law, Subscribers who are approved for long-term disability benefits under either the Public Employees Long-Term Disability Program under Utah Code Annotated Title 49, Chapter 21, or from another Employer-sponsored long-term disability program substantially similar to the Public Employees Long-Term Disability Program, are eligible to continue Coverage with PEHP until the earlier of:

1. The Subscriber no longer receiving long-term disability benefits;
2. The Subscriber's failure to make the required Payment to PEHP each month as set forth below;
3. Group cancellation of medical Coverage with PEHP;
4. The Subscriber or Subscriber's spouse reaching the first of the month in which the Subscriber or Subscriber's spouse attains the age of 65; or
5. The Subscriber or Subscriber's spouse turning 65 will be eligible to continue with a PEHP-sponsored Medicare Supplement plan.
6. For subscribers and their dependents covered under a substantially equivalent long-term disability program, the date the Public Employees Long-Term Disability benefit would end pursuant to Utah Code Annotated Title 49, Chapter 21.

The Subscriber or the Subscriber's spouse who is younger than 65, or any other Dependents covered on the plan younger than 65, will remain eligible for PEHP Coverage until they meet one of the other criteria listed above or no longer meet Dependent eligibility criteria.

The Payment for each disabled Subscriber who qualifies for PEHP Coverage shall be 102% of the regular active Employee Payment. Each disabled Subscriber must pay all or a portion of the monthly PEHP Payment to remain eligible for PEHP benefits as set forth below. The remainder of the monthly Payment, if any, shall be waived by PEHP. The disabled Subscriber shall pay 10% of the monthly PEHP Payment for the first year of eligibility beginning the day after the last day of actual work or last day on Family Medical Leave, 20% for the second year of disability (based off of last day worked), and 30% the third and subsequent years on disability (based on last day worked). The monthly PEHP Payment shall be set by PEHP. Notwithstanding the above percentages, if the disabled Subscriber is more than 30 days in arrears on paying money owed to the Public Employees Long-Term Disability Program, the disabled Subscriber shall pay the full monthly Payment to PEHP.

PEHP, in its sole discretion, shall determine whether another disability benefit is substantially similar to the PEHP LTD Program.

