PEHP Health & Benefits

STAR HSA Option 1

Summit Exclusive

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.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,600 Double/family plans: $5,200 *One person cannot apply more than $2,600 toward the double/family deductible*	Single plans: $3,000 Double/family plans: $6,000
Plan year Out-of-Pocket Maximum	Single plans: $2,600 Double/family plans: $5,200 *One person cannot apply more than $2,600 toward the double/family maximum*	Single plans: $4,000 Double/family plans: $8,000
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	Not covered
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** No charge after deductible	Not applicable
PEHP Value Clinics	**Medical:** No charge after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	No charge after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	No charge after deductible	40% after deductible
Surgery and Anesthesia	No charge after deductible	40% after deductible
Emergency Room Specialist Visits	No charge after deductible	No charge after deductible
Diagnostic Tests, Labs, X-rays	No charge after deductible	40% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service.* *Inpatient services require preauthorization*	No charge after deductible	Not covered
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible . For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** No charge **Tier 2:** No charge **Tier 3:** No charge	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** No charge **Tier 2:** No charge **Tier 3:** No charge	Not covered

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

Medical Benefits: STAR HSA Option 1

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** No charge **Tier B:** No charge	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** No charge **Tier B:** No charge	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 20% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** No charge **Tier B:** No charge **Tier C:** No charge	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	No charge after deductible	40% after deductible
Urgent Care Facility	No charge after deductible	40% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	No charge after deductible	No charge after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	No charge after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	No charge after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	No charge after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization. See Master Policy for details*	No charge after deductible	40% after deductible
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	No charge after deductible	40% after deductible
Hospice	No charge after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	No charge after deductible	40% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	No charge after deductible	40% after deductible

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MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge after deductible, up to $4,000 per adoption	
Allergy Serum	No charge after deductible	40% after deductible
Chiropractic care | *Up to 20 visits per plan year*	No charge after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	No charge after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	No charge after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	No charge after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	Not covered	Not covered
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	Not covered	Not covered