Wasatch Behavioral Health

Effective July 1, 2023 – June 30, 2024

Wasatch Behavioral Health Benefits Summary

WASATCH BEHAVIORAL HEALTH

Benefits Summary

Effective July 2023

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 Wasatch Behavioral Health 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.

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. 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.

3-16-23

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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

Create your personal account at 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

GROUP TERM LIFE AND AD&D

» PEHP Life and AD&D 801-366-7495

HEALTH SAVINGS ACCOUNTS (HSA)

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

WELLNESS AND CARE MANAGEMENT

» PEHP Healthy Utah 801-366-7300
or 855-366-7300
www.pehp.org/wellness

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

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

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

VALUE-ADDED BENEFITS

» PEHPplus ..... www.pehp.org/pehpplus

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

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. Available on all PEHP networks. Learn More

PEHP Cost Tools

Get the Most out of Your Healthcare Dollars » Find the best care at the best value using PEHP Cost Tools. You may even find cash back for eligible services. 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

Know Before You Go

Five 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

Find a Provider

Looking for a provider, clinic, or facility that is contracted with your plan? Visit the PEHP Provider Directory and log in to your PEHP account 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.

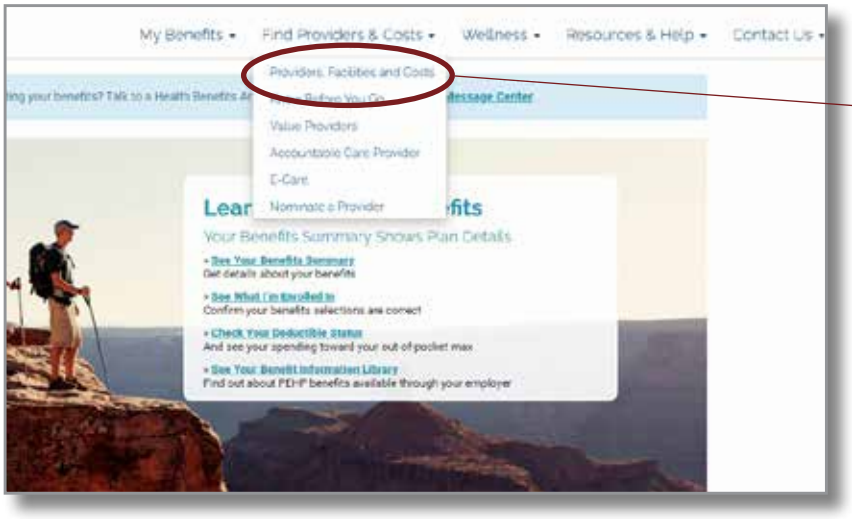
The amount you pay for charges above the In-Network Rate won't apply to your deductible or out-of-pocket maximum.

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 and log in to your PEHP account to see which network includes your doctors.

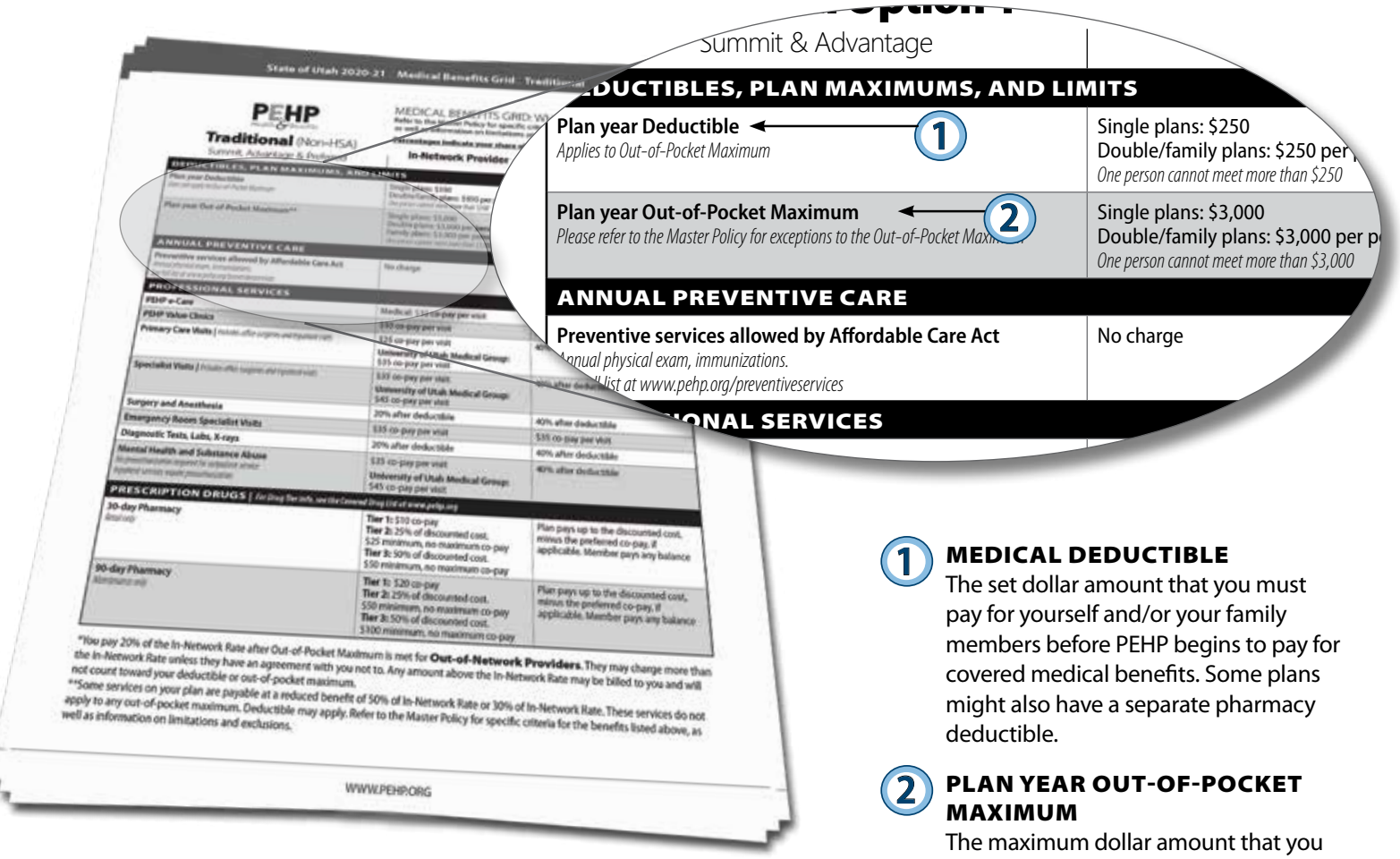
Ask questions before you get medical care. Make sure every person and every facility involved is contracted in your network.

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.



Go to www.pehp.org, log into your PEHP account, and click on *Providers, Facilities and Costs* under the *Find Providers and Costs* menu to find a doctor or facility in your network.

Understanding Your Benefits Grid



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.

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.

For more definitions, please see the Master Policy.

PEHP Health & Benefits

Traditional

Summit & Advantage

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: $500 Double/family plans: $500 per person, $1,000 per family *One person cannot meet more than $500*	Single plans: $1,000 Double/family plans: $1,000 per person, $2,000 per family *One person cannot meet more than $1,000*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the out-of-pocket maximum*	Single plans: $3,500 Double/family plans: $3,500 per person, $7,000 per family *One person cannot meet more than $3,500*	Single plans: $7,000 Double/family plans: $7,000 per person, $14,000 per family *One person cannot meet more than $7,000*
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
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit	35% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit	35% after deductible
Surgery and Anesthesia	15% after deductible	35% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit	$35 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	35% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	35% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 50% of discounted cost, $50 minimum / $100 maximum	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:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost, $100 minimum / $200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*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 will be billed to you and will not count toward your deductible or out-of-pocket maximum.

	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:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	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:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	15% after deductible	35% after deductible
Urgent Care Facility	$40 co-pay per visit	35% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$100 co-pay after deductible per visit	$100 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% 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	35% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	15% after deductible	35% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	15% after deductible	35% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	35% after deductible
Mental Health & Substance Abuse	25% after deductible	35% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	15% after deductible	35% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	15% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	15% after deductible	35% after deductible
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	15% after deductible Summit Network: Alpine Home Medical	35% after deductible
Medical Supplies *See Master Policy for benefit limits*	15% after deductible	35% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge	35% after deductible
Hospice	15% after deductible	35% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 15% after deductible	35% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	15% after deductible	35% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	15% after deductible	35% after deductible

PEHP Health & Benefits

STAR HSA

Summit & Advantage

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: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*	Single plans: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $4,000 double/family deductible*
Plan year Out-of-Pocket Maximum	Single plans: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $6,000 double/family maximum*	Single plans: $6,000 Double/family plans: $12,000 *One person or a combination can meet the $12,000 double/family out-of-pocket-maximum*
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
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	10% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	10% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	10% after deductible	40% after deductible
Surgery and Anesthesia	10% after deductible	40% after deductible
Emergency Room Specialist Visits	10% after deductible	10% after deductible
Diagnostic Tests, Labs, X-rays	10% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 50% of discounted cost, $50 minimum / $100 maximum	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:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost, $100 minimum / $200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*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 will be billed to you and will not count toward your deductible or out-of-pocket maximum.

	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:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	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:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	10% after deductible	40% after deductible
Urgent Care Facility	10% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	10% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	10% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	10% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	10% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	10% after deductible	40% after deductible
Mental Health & Substance Abuse	10% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	10% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	10% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	10% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	10% after deductible	40% after deductible
Chiropractic care | *Up to 20 visits per plan year*	10% after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	10% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	10% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	10% after deductible	40% after deductible
Hospice	10% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	10% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	10% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	10% after deductible	40% after deductible

Additional PEHP Benefits

This is a brief summary of additional benefits PEHP offers.

Healthy Utah Biometric Screenings

Complete a biometric screening (cholesterol, blood glucose, body composition, and blood pressure) at a Healthy Utah session or your annual preventive doctor office visit to earn rebates. Rebates may not apply to all plans. Learn more.

Legal Guardianship

This benefit allows children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. To continue coverage, the guardian child must have been enrolled in coverage prior to being 18 years of age and met the federal qualifications for coverage as a guardian child. Call PEHP to learn more, 801-366-7555 or 800-765-7347.

Preventive Medications Covered Before Deductible

If you're on the STAR HSA Plan, certain chronic medications are covered before you meet your deductible. See a list of medications on page 19 of the Covered Drug List.

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 screening each plan year. 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**
» **Web: www.pehp.org/wellness**

PEHP WeeCare

PEHP WeeCare is a pregnancy and postpartum program to support and inform PEHP members. Our goal is to help expectant mothers have the healthiest and safest pregnancy possible. All PEHP members are eligible to participate.

Members may enroll at any time during the pregnancy to participate in PEHP WeeCare and receive a rebate from PEHP. If you enroll postpartum you can still participate; however, you will not be eligible for the rebate. See the WeeCare brochure and/or rebate form for detailed instructions and how to qualify for rebates.

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**
» **Web: www.pehp.org/wellness**

**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

This lifestyle behavior change program provides education, support, and accountability to help you succeed in meeting your health and weight management goals. Available to members, spouses and dependents age 6 and older.

FOR MORE INFORMATION

PEHP Health Coaching
801-366-7300 | 855-366-7300
» **E-mail: healthcoaching@pehp.org**
» **Web: www.pehp.org/wellness**

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.

» **Web: www.pehp.org/pehpplus**

PEHP Dental Care

Introduction

PEHP wants to keep you healthy and smiling brightly. We offer dental plans that provide coverage for a full range of dental care.

When you use In-Network providers, you pay a specified copayment and PEHP pays the balance. When you use Out-of-Network providers, PEHP pays a specified portion of the In-Network Rate, and you are responsible for the balance.

There is no deductible for Preventive or Diagnostic services.

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines when you log in to your PEHP account. The Master Policy is available at PEHP for Members at www.pehp.org.

Call PEHP Customer Service to request a copy.

Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

There is a Waiting Period of six months from the effective date of Coverage for Orthodontic, Implant, and Prosthodontic benefits.

Members returning from military service will have the six-month waiting period for orthodontics waived if they reinstate their dental coverage within 90 days of their military discharge date.

NOTICE: Depending on your Employer's choice of Dental coverage plans, the Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits may not apply. Please refer to your Employer or call PEHP Customer Service for details.

Missing Tooth Exclusion

Services to replace teeth that are missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous Coverage with PEHP. However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge, denture, or implant was in place at the time the coverage became effective.

NOTICE: Depending on your Employer's choice of Dental coverage plans, the Missing Tooth Exclusion may not apply. Please refer to your Employer or call PEHP Customer Service for details.

Limitations and Exclusions

Written preauthorization may be required for prosthodontic services. Preauthorization is not required for orthodontics.

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

Preferred Dental Care

	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	**20%** of In-Network Rate	**40%** of In-Network Rate
PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All eligible related services	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum	

For dental services covered by PEHP medical plans, there is no dental plan coverage.

PEHP Life & Accident

Enrollment is Easy and Affordable » Give your loved-ones long-term financial protection in the event of your death. Protect your family's finances in the event of your spouse or dependent child's death.

Enroll at Any Time

Open Enrollment is a great time to consider Life & Accident coverage. But you can enroll at any time at www.pehp.org. Log in to your PEHP account and select "Enroll or Change Coverage" from the "My Benefits" menu.

Group Term Life Coverage

Buy coverage at varying amounts for yourself, your spouse, and your children. Costs are based on your amount of coverage and age.

Accidental Death and Disability

Pays benefits in the event of your death or injury in an accident. You can buy up to $250,000 in coverage, and rates are the same regardless of your age.

Other Benefits

Accidental Weekly Indemnity provides you with additional income if you miss work because of a non-job-related accident. Accident Medical Expense helps pay medical expenses beyond what insurance pays if you're injured in a non-job-related accident.

Learn More

Contact PEHP Life & Accident: 801-366-7495 or 800-753-7495. See instructions below to download the PEHP Life & Accident brochure or email publications@pehp.org to request a printed copy.

See costs and coverage here. To read the PEHP Life & Accident brochure and Master Policy in the Benefits Information Library, select "Benefits Summaries" from the "My Benefits" menu.