

# Unified Fire Authority 2008

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## Advantage Care Medical Benefits Summary

This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP Members who are employed by Unified Fire Authority. Members of any other PEHP plan should refer to the applicable publications for their Coverage.

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The PEHP Master Policy contains a detailed description of the benefits of each plan. The Master Policy is subject to change each plan year.

It is important for you to familiarize yourself with the information provided in the Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP Customer Service, or you may view an online version on the PEHP website at [www.pehp.org](http://www.pehp.org).

**Public Employees  
Health Program**



# Advantage Care Medical Benefits Summary

## Introduction

This Benefits Summary amends the 2008 - 2009 PEHP Master Policy as set forth herein. The Benefits Summary is a description of Eligible Benefits and/or Copayments when all eligibility requirements are met. Some benefits are subject to reduced percentages and/or dollar limitations. For a complete description, see the Plan guidelines, Limitations and Exclusions sections of the Advantage Provider Plans Master Policy at [www.pehp.org](http://www.pehp.org).

All benefits are subject to the maximum allowable Advantage Care Schedule of Benefits (ACSB) as determined by the Public Employees Health Program (PEHP) and the Maximum yearly or Lifetime limits. **Refer to the Advantage Provider Plans Master Policy for specific criteria for benefits, as well as information on Limitations and Exclusions.**

The text of the Master Policy sometimes includes specific benefits that are applicable to the majority of covered agencies, but could vary in some cases. This Benefits Summary takes precedent over the Master Policy text in these instances. You can review the Master Policy at [www.pehp.org](http://www.pehp.org) or contact PEHP at 801-366-7555 or 1-800-765-7347 and request a copy.

## PRE-NOTIFICATION/PRE-AUTHORIZATION

To be eligible, **all** inpatient hospitalization requires Pre-notification and some other services require Pre-authorization by PEHP and will be subject to a reduction or denial of benefits if not complete. For a complete list of services that require Pre-authorization and Pre-notification, please see your PEHP Master Policy at [www.pehp.org](http://www.pehp.org). Failure to Pre-notify inpatient hospitalization will result in a reduction of benefits of \$100 per day, up to a \$500 maximum. No benefits are payable for Mental Health or substance abuse admissions without Pre-authorization.

Pre-notified or Pre-authorized benefits are subject to all plan provisions and eligibility at time of service, and plan changes with new plan year provisions.

Some prescription drugs may require Pre-authorization through the Medco Health Managed Care Prior Authorization Department. (See the Limitations in the Pharmacy section of the Advantage Provider Plans Master Policy at [www.pehp.org](http://www.pehp.org).)

## NON-CONTRACTED PROVIDERS

When using non-Contracted Providers, benefits will be payable at a reduced percentage of ACSB, minus applicable Copayment(s), and the Member will be responsible for any remaining balance.

## SERVICE AREA

You must live in one of the following counties to be eligible to enroll in PEHP Advantage Care: Beaver, Box Elder, Cache, Daggett, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber.

## ENROLLMENT PERIOD

A Subscriber has 60 days from his/her hire date to enroll for Coverage. If the Subscriber fails to enroll during this time period he/she must wait until the next annual enrollment period to enroll.

Spouse and Dependent children may be enrolled within 60 days from the date of birth or placement in your home, or from the date of marriage. If not enrolled during this time period, Dependents must wait until the next enrollment period to be eligible for Coverage in the next contract year.

For more detailed information regarding enrollment and eligibility issues, please refer to the Master Policy at [www.pehp.org](http://www.pehp.org).

# Advantage Care Medical Benefits Summary

Refer to the Advantage Care Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

DEDUCTIBLES, OUT-OF-POCKET LIMITS, LIFETIME MAXIMUM, PRE-EXISTING CONDITIONS	
<b>Using Contracted Providers</b>	
<i>Yearly Deductible</i>	None
<i>Yearly Out-of-pocket Maximum</i>	\$1,000 per individual, \$2,000 per family
<i>Maximum Lifetime Benefit</i>	None
<i>Pre-existing Condition Clause</i>	9-month Waiting Period, waived with evidence of Prior Credible Coverage
<b>Using Non-Contracted Providers*</b>	
<i>Yearly Deductible</i>	\$250 per individual, \$500 per family
<i>Yearly Out-of-pocket Maximum</i>	\$3,000 per individual, \$6,000 per family
<i>Maximum Lifetime Benefit</i>	\$1,000,000 per individual
<i>Pre-existing Condition Clause</i>	9-month Waiting Period waived with evidence of Prior Credible Coverage
<b>Mental Health and Substance Abuse Out-of-Pocket Limits</b> Separate Yearly Out-of-pocket Maximum	\$1,000 per individual, \$2,000 per family

\*When using Non-Contracted Providers, benefits will be payable per ACSB, (Advantage Care Schedule of Benefits) minus applicable Copayments. Member will be responsible for any remaining balance.

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
<b>Adoption</b>	100% up to \$4,000. See Limitations	100% up to \$4,000. See Limitations
<b>Allergy Injections</b>	100% of ACSB	70% of ACSB after Deductible
<b>Allergy Serum</b>	90% of ACSB	70% of ACSB after Deductible
<b>Ambulance</b> , ground or air	80% of ACSB	80% of ACSB after Deductible
<b>Ambulatory Surgical Facility</b>	90% of ACSB	70% of ACSB after Deductible
<b>Anesthesia</b>	90% of ACSB	70% of ACSB after Deductible
<b>Assistant Surgeon</b>	90% of ACSB (ACSB is 20% of allowable surgical fee or 10% for a PA or RN assistant)	70% of ACSB after Deductible (ACSB is 20% of allowable surgical fee or 10% for a PA or RN assistant)
<b>Cardiac Rehabilitation</b> , Phase 2	100% of ACSB after applicable office Copayment per visit, up to 24 visits allowed per plan year	70% of ACSB after Deductible, up to 24 visits allowed per plan year
<b>Chemotherapy</b> Outpatient, Office, Home	90% of ACSB	70% of ACSB after Deductible
<b>Chiropractic Therapy</b>	100% of ACSB after applicable office Copayment per visit, up to 20 visits per plan year Requires Pre-authorization after 8 visits	70% of ACSB after Deductible, up to 20 visits per plan year. Requires Pre-authorization after 8 visits
<b>Diabetes Education</b> (must be for the diagnosis of diabetes)	100% of ACSB after applicable office Copayment per visit	70% of ACSB after Deductible
<b>Diagnostic Radiology</b>		
<i>Inpatient Facility</i>	90% of ACSB	70% of ACSB after Deductible
<i>Outpatient</i>	100% of ACSB for each service up to \$350 80% of ACSB for each service allowing more than \$350	70% of ACSB after Deductible
<i>Inpatient/Outpatient Physician</i>	100% of ACSB for each service up to \$350 80% of ACSB for each service allowing more than \$350	70% of ACSB after Deductible

## Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
<b>Diagnostic Testing/Laboratory</b>		
<i>Inpatient Facility</i>	90% of ACSB	70% of ACSB after Deductible
<i>Outpatient</i>	100% of ACSB for each test up to \$350. 80% of ACSB for each test allowing more than \$350	70% of ACSB after Deductible
<i>Inpatient/Outpatient Physician</i>	100% of ACSB for each test up to \$350 80% of ACSB for each test allowing more than \$350	70% of ACSB after Deductible
<i>Transplant Donor Typing</i>	Same as above up to \$5,000 Maximum	Same as above up to \$5,000 Maximum
<b>Dialysis, Outpatient, Home</b>	90% of ACSB	70% of ACSB after Deductible. Requires Pre-authorization
<b>Emergency Room</b>		
<i>Facility</i>	100% of ACSB after \$75 Copayment per visit	100% of ACSB after \$150 Copayment per visit
<i>Physician</i>	100% of ACSB after \$15 Copayment per visit	70% of ACSB after Deductible
<i>Specialist</i>	100% of ACSB after \$20 Copayment per visit	70% of ACSB after Deductible
<b>Eye/Vision Exams</b>	100% of ACSB after applicable office Copayment per visit	70% of ACSB after Deductible
<b>Functional Reconstructive Surgery</b>	90% of ACSB Requires Pre-authorization	70% of ACSB after Deductible Requires Pre-authorization
<b>Hemophilia Factor Products</b>	80% of ACSB	70% of ACSB after Deductible
<b>Home Healthcare</b>	All services require Pre-authorization and Medical Case Management	
<i>Skilled Nursing</i>	100% of ACSB (up to 60 visits allowed per plan year)	70% of ACSB after Deductible (up to 60 visits allowed per plan year)
<i>IV Therapy (antibiotics)</i>	100% of ACSB	70% of ACSB after Deductible
<i>Chemotherapy, Dialysis</i>	90% of ACSB	70% of ACSB after Deductible
<i>Physical, Occupational, Speech Therapy</i>	100% of ACSB after applicable office Copayment per visit. Maximum limits apply	70% of ACSB after Deductible. Maximum limits apply
<i>LCSW</i>	100% of ACSB after applicable office Copayment per visit as a mental health benefit	Non-covered
<i>Total Parenteral Nutrition (TPN)</i>	80% of ACSB	70% of ACSB after Deductible
<i>Enteral (Tube) Feeding supplies</i>	80% of ACSB	70% of ACSB after Deductible
<i>Enteral Formula</i>	If approved, must be obtained through the Pharmacy Card	Non-covered
<b>Hospice Services</b>	100% of ACSB up to 6 months in a 3-year period Requires Pre-authorization and Medical Case Management	70% of ACSB after Deductible up to 6 months in a 3-year period. Requires Pre-authorization and Medical Case Management
<b>Hospital</b>		
<i>Inpatient</i>	90% of ACSB. Requires Pre-notification	70% of ACSB after Deductible. Requires Pre-notification
<i>Outpatient</i>	90% of ACSB	70% of ACSB after Deductible
<i>Physician Visits</i>	100% of ACSB after applicable office Copayment per visit	70% of ACSB after Deductible
<b>Hyperbaric Oxygen Treatment</b>	80% of ACSB. Requires Pre-authorization	70% of ACSB after Deductible. Requires Pre-authorization
<b>Immunizations</b>	100% of ACSB	70% of ACSB after Deductible
<b>Infertility</b>	50% of ACSB. See Limitations	50% of ACSB after Deductible. See Limitations
<b>Injections</b>	Pre-authorization required if over \$750	
<i>Under \$50</i>	100% of ACSB	70% of ACSB after Deductible
<i>Over \$50</i>	80% of ACSB	70% of ACSB after Deductible

## Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
<b>Jaw Surgery (Osteotomy/TMJ Surgery)</b>	90% of ACSB	70% of ACSB after Deductible
<b>Mammogram, routine</b>	100% of ACSB	70% of ACSB after Deductible
<b>Medical Equipment (DME)</b>	All DME over \$750, any rental that exceeds 60 days, or as indicated in Appendix A to the Master Policy requires Pre-authorization	
<i>General</i>	80% of ACSB	70% of ACSB after Deductible
<i>Sleep Disorder</i>	80% of ACSB, up to \$2,500 in a 5-year period	70% of ACSB after Deductible, up to \$2,500 in a 5-year period
<i>TENS Unit</i>	80% of ACSB, up to \$500 Lifetime Maximum	70% of ACSB after Deductible, up to \$500 Lifetime Maximum
<i>Neuromuscular Stimulator</i>	80% of ACSB, up to \$1,000 Lifetime Maximum	70% of ACSB after Deductible, up to \$1,000 Lifetime Maximum
<i>Interferential Stimulator</i>	80% of ACSB, up to \$2,000 Lifetime Maximum	70% of ACSB after Deductible, up to \$2,000 Lifetime Maximum
<i>H-Wave Electronic Device</i>	80% of ACSB, up to \$2,000 Lifetime Maximum	70% of ACSB after Deductible, up to \$2,000 Lifetime Maximum
<i>Sympathetic Therapy Stimulator (STS)</i>	80% of ACSB, up to \$2,000 Lifetime Maximum	70% of ACSB after Deductible, up to \$2,000 Lifetime Maximum
<i>Wheelchairs (including parts and replacements)</i>	80% of ACSB, up to \$20,000 in a 5-year period See Limitations	70% of ACSB after Deductible, up to \$20,000 in a 5-year period See Limitations
<i>Knee Braces</i>	80% of ACSB, up to \$1,500 in a 3-year period See Limitations	70% of ACSB after Deductible, up to \$1,500 in a 3-year period See Limitations
<b>Mental Healthcare</b>	Requires Pre-authorization through Mental Health Care of Utah (MHCU) at 1-800-541-9432	
<i>Inpatient Hospital</i>	50% of ACSB	Non-covered
<i>Inpatient Physician Visits</i>	50% of ACSB	Non-covered
<i>Outpatient Therapy</i>	100% of ACSB after applicable office Copayment per visit.	Non-covered
<b>Neuro-psychiatric Testing</b>	100% of ACSB for each test up to \$350 80% of ACSB for each test allowing more than \$350	70% of ACSB after Deductible
<b>Occupational Therapy, Outpatient, Home</b>	100% of ACSB after applicable office Copayment per visit, up to 8 visits per plan year	70% of ACSB after Deductible, up to 8 visits per plan year
<b>Office Visits</b>	100% of ACSB after \$15 Copayment per visit	70% of ACSB after Deductible
<i>Specialist Visit</i>	100% of ACSB after \$20 Copayment per visit	70% of ACSB after Deductible
<i>After-Hours Visit</i>	100% of ACSB after \$30 Copayment per visit	70% of ACSB after Deductible
<b>Pain Clinics/Treatment</b>		
<i>Inpatient</i>	Mental Health Benefits apply Requires Pre-authorization through PEHP	Non-covered
<i>Outpatient Facility/Surgical Suite</i>	90% of ACSB	70% of ACSB after Deductible
<i>All services related to: Trigger Point, Sacroiliac Joint, Nerve Block, Epidural Steroid and/or Facet Injections</i>	90% of ACSB up to \$5,000 per plan year	70% of ACSB after Deductible up to \$5,000 per plan year
<i>Office</i>	First 5 visits payable at 100% of ACSB after applicable office Copayment per visit	First 5 visits payable at 70% of ACSB after Deductible
<i>Repetitive Visits/Other Injections</i>	50% of ACSB after 5 visits up to \$1,500 per plan year	50% of ACSB after Deductible after 5 visits up to \$1,500 per plan year
<b>Pap Smear, routine</b>	100% of ACSB	70% of ACSB after Deductible
<b>Physical Examinations</b>	100% of ACSB after applicable office Copayment per visit	70% of ACSB after Deductible
<b>Physical Therapy</b>		
<i>Inpatient</i>	90% of ACSB	70% of ACSB after Deductible
<i>Outpatient/Home</i>	100% of ACSB after applicable office Copayment per visit, up to 20 visits per plan year	70% of ACSB after Deductible, up to 20 visits per plan year

## Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
<b>Prescription Drugs (RX Selections Formulary)</b>	Refills at retail and/or mail order are not payable until 70% of total day supply within the last 180 days is used Generic required if available. If brand name is selected when generic is available, member pays generic cost plus difference to name brand.	
<i>Retail, up to 30-day supply.</i>	<b>Generic Drug</b> — 80% of discounted cost; \$5 minimum Copayment. <b>Preferred Brand Name Drug</b> — 75% of discounted cost; \$5 minimum Copayment. <b>Non-preferred Brand Name Drug</b> — 50% of discounted cost; \$5 minimum Copayment	Plan pays up to the discounted cost, minus the Preferred Copayment. Member pays any balance
<i>Mail Order, up to 90-day supply</i>	<b>Generic Drug</b> —80% of discounted cost; \$5 minimum Copayment, \$50 maximum Copayment. <b>Preferred Brand Name Drug</b> —75% of discounted cost; \$5 minimum Copayment, \$50 maximum Copayment. <b>Non-preferred Brand Name Drug</b> — 50% of discounted cost; \$5 minimum Copayment	Non-covered
<i>Compound Drugs</i>	50% of discounted cost	Plan pays up to the discounted cost, minus the Preferred Copayment. Member pays any balance
<i>Diabetic Supplies</i>	Pharmacy benefits apply	Plan pays up to the discounted cost, minus the Preferred Copayment. Member pays any balance
<i>Enterals</i>	80% of discounted cost Requires Pre-authorization and Medical Case Management	Non-covered
<i>Food Supplements</i>	Non-covered, except as required for phenylketonuria (PKU). Requires Pre-authorization and Medical Case Management. If approved, Pharmacy benefits apply	Non-covered
<i>Foreign Country Claims</i>	Medical benefits apply	Medical benefits apply
<i>Smoking Cessation</i>	Pharmacy benefits apply up to a 3-month supply in a rolling 365-day period	Plan pays up to the discounted cost, minus the Preferred Copayment, up to a 3-month supply in a rolling 365-day period. Member pays any balance
<i>Specialty Drug Program, up to 30-day supply</i>	80% of discounted cost up to a \$100 maximum Copayment. See Appendix B to the Master Policy for the specialty drugs covered under this benefit	Non-covered
<b>Prosthetics</b>	80% of ACSB Up to \$20,000 in a 5-year period (per limb) Requires Pre-authorization and Medical Case Management	70% of ACSB after Deductible Up to \$20,000 in a 5-year period (per limb) Requires Pre-authorization and Medical Case Management
<b>Psychiatric Testing</b>	100% of ACSB for each test up to \$350. 80% of ACSB or each test allowing more than \$350	Non-covered
<b>Pulmonary Rehabilitation, Phase 2</b>	100% of ACSB after applicable office Copayment per visit, up to 24 visits allowed per plan year	70% of ACSB after Deductible, up to 24 visits allowed per plan year
<b>Radiation Therapy</b>	90% of ACSB	70% of ACSB after Deductible
<b>Rehabilitation, Inpatient</b>	90% of ACSB up to \$75,000 Lifetime Maximum. Requires Pre-authorization and Medical Case Management	70% of ACSB after Deductible, up to \$75,000 Lifetime Maximum. Requires Pre-authorization and Medical Case Management
<b>Second Surgical Opinion</b>	100% of ACSB	100% of ACSB
<b>Skilled Nursing Facility (SNF), non-custodial</b>	90% of ACSB Requires Pre-authorization and Medical Case Management	70% of ACSB after Deductible Requires Pre-authorization and Medical Case Management
<b>Sleep Studies</b>	80% of ACSB, up to \$2,000 maximum in a 3-year period	70% of ACSB after Deductible, up to \$2,000 maximum in a 3-year period
<b>Speech Therapy</b>	100% of ACSB after applicable office Copayment per visit. Lifetime Maximum of 60 visits (must meet criteria to be Eligible)	70% of ACSB after Deductible. Lifetime Maximum of 60 visits (must meet criteria to be Eligible)

## Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
<b>Substance Abuse Treatment</b>	Requires Pre-authorization through Mental Health Care of Utah (MHCU) at 1-800-541-9432	
<i>Inpatient Hospital</i>	50% of ACSB	Non-covered
<i>Inpatient Physician Visits</i>	50% of ACSB	Non-covered
<i>Outpatient Therapy</i>	100% of ACSB after applicable office Copayment per visit	Non-covered
<b>Surgery, Physician</b>		
<i>Inpatient/Outpatient Facility</i>	90% of ACSB	70% of ACSB after Deductible
<i>Physician's Office</i>	100% of ACSB after applicable office Copayment per visit	70% of ACSB after Deductible
<b>Take Home Medications</b>	80% of ACSB	70% of ACSB after Deductible
<b>Temporomandibular Joint Dysfunction (TMJ, TMD)</b>	50% of ACSB, up to a \$1,000 Lifetime Maximum	50% of ACSB after Deductible, up to a \$1,000 Lifetime Maximum
<b>Transplants</b>	Payable with applicable Copayments per service rendered. Requires Pre-authorization and Medical Case Management (must meet criteria to be Eligible)	Payable with applicable Copayments per service rendered. Requires Pre-authorization and Medical Case Management (must meet criteria to be Eligible)
<b>Urgent Care Facility</b>	100% of ACSB after \$30 Copayment per visit	70% of ACSB after Deductible