

Unified Fire Authority 2008

Summit 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.

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.

**Public Employees
Health Program**



Summit Care Medical Benefits Overview

Introduction

This Benefits Summary amends the 2008-2009 PEHP Summit Care Master Policy as set forth herein. The Benefits Summary is a brief overview 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 and Limitations and Exclusions sections of the Summit Care Medical Master Policy at www.pehp.org.

All benefits are subject to the maximum allowable Summit Care Schedule of Benefits (SCSB) as determined by PEHP and the Maximum yearly or Lifetime limits. **Refer to the Summit Care 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. The Benefits Summary takes precedence over the Master Policy text in these instances. You can review the Summit Care Master Policy at www.pehp.org or contact PEHP at 1-801-366-7555 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 the Summit Care PEHP Master Policy at 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 Summit Care Master Policy at www.pehp.org.)

NON-CONTRACTED PROVIDERS

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

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.

SERVICE AREA

PEHP Summit Care is only available to employees who live in Utah (residents of all Utah counties are eligible).

Summit Care Medical Benefits Summary

Refer to the Summit 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	
Using Contracted Providers	
<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 Creditable Coverage
Using Non-Contracted Providers*	
<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 Creditable Coverage
Mental Health and Substance Abuse Out-of-Pocket limits Separate Yearly Out-of-pocket Maximum	\$1,000 per individual, \$2,000 per family

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

Coverage Levels (continued)

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

Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
Infertility	50% of SCSB. See limitations	50% of SCSB after Deductible. See Limitations
Injections	Requires Pre-authorization 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
Jaw Surgery (Osteotomy/TMJ Surgery)	90% of SCSB	70% of SCSB after Deductible
Mammogram, routine	100% of SCSB	70% of SCSB after Deductible
Medical Equipment (DME)	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 SCSB	70% of SCSB after Deductible
<i>Sleep Disorder</i>	80% of SCSB, up to \$2,500 in a 5-year period	70% of SCSB after Deductible, up to \$2,500 in a 5-year period
<i>TENS Unit</i>	80% of SCSB, up to \$500 Lifetime Maximum	70% of SCSB after Deductible, up to \$500 Lifetime Maximum
<i>Neuromuscular Stimulator</i>	80% of SCSB, up to \$1,000 Lifetime Maximum	70% of SCSB after Deductible, up to \$1,000 Lifetime Maximum
<i>Interferential Stimulator</i>	80% of SCSB, up to \$2,000 Lifetime Maximum	70% of SCSB after Deductible, up to \$2,000 Lifetime Maximum
<i>H-Wave Electronic Device</i>	80% of SCSB, up to \$2,000 Lifetime Maximum	70% of SCSB after Deductible, up to \$2,000 Lifetime Maximum
<i>Sympathetic Therapy Stimulator (STS)</i>	80% of SCSB, up to \$2,000 Lifetime Maximum	70% of SCSB after Deductible, up to \$2,000 Lifetime Maximum
<i>Wheelchairs</i> (including parts and replacements)	80% of SCSB, up to \$20,000 in a 5-year period. See Limitations	70% of SCSB after Deductible, up to \$20,000 in a 5-year period. See Limitations
<i>Knee Braces</i>	80% of SCSB, up to \$1,500 in a 3-year period See Limitations	70% of SCSB after Deductible. Requires Pre-authorization
Mental Healthcare	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
Neuro-psychiatric Testing	100% of SCSB for each test up to \$350 80% of SCSB for each test allowing more than \$350	70% of SCSB after Deductible
Occupational Therapy , Outpatient/Home	100% of SCSB after applicable office Copayment per visit, up to 8 visits per plan year	70% of SCSB after Deductible, up to 8 visits per plan year
Office Visits	100% of SCSB after \$15 Copayment per visit	70% of SCSB after Deductible
<i>Specialist Visit</i>	100% of SCSB after \$20 Copayment per visit	70% of SCSB after Deductible
<i>After-Hours Visit</i>	100% of SCSB after \$30 Copayment per visit	70% of SCSB after Deductible
Pain Clinics/Treatment		
<i>Inpatient</i>	Mental Health Benefits apply Requires Pre-authorization through PEHP	Non-covered
<i>Outpatient Facility/Surgical Suite</i>	90% of SCSB	70% of SCSB 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 SCSB after applicable office Copayment per visit	First 5 visits payable at 70% of SCSB after Deductible
<i>Repetitive Visits/Other Injections</i>	50% of SCSB after 5 visits up to \$1,500 per plan year	50% of SCSB after Deductible after 5 visits up to \$1,500 per plan year
Pap Smear, routine	100% of SCSB	70% of SCSB after Deductible

Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
Physical Examinations	100% of SCSB after applicable office Copayment per visit	70% of SCSB after Deductible
Physical Therapy		
<i>Inpatient</i>	90% of SCSB	70% of SCSB after Deductible
<i>Outpatient/Office</i>	100% of SCSB after applicable office Copayment per visit up to 20 visits per plan year	70% of SCSB after Deductible, up to 20 visits per plan year
Prescription Drugs (RX Selections Formulary)	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>	Generic Drug — 80% of discounted cost; \$5 minimum Copayment. Preferred Brand Name Drug — 75% of discounted cost; \$5 minimum Copayment. Non-preferred Brand Name Drug — 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>	Generic Drug —80% of discounted cost; \$5 minimum Copayment, \$50 maximum Copayment. Preferred Brand Name Drug —75% of discounted cost; \$5 minimum Copayment, \$50 maximum Copayment. Non-preferred Brand Name Drug — 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
Prosthetics	80% of SCSB up to \$20,000 in a 5-year period (per limb). Requires Pre-authorization and Medical Case Management	70% of SCSB after Deductible, up to \$20,000 in a 5-year period (per limb) Requires Pre-authorization and Medical Case Management
Psychiatric Testing	100% of SCSB for each test up to \$350 80% of SCSB or each test allowing more than \$350	Non-covered
Pulmonary Rehabilitation, Phase 2	100% of SCSB after applicable office Copayment per visit, up to 24 visits allowed per plan year	70% of SCSB after Deductible, up to 24 visits allowed per plan year
Radiation Therapy	90% of SCSB	70% of SCSB after Deductible
Rehabilitation, Inpatient	90% of SCSB up to \$75,000 Lifetime Maximum Requires Pre-authorization and Medical Case Management	70% of SCSB after Deductible, up to \$75,000 Lifetime Maximum Requires Pre-authorization and Medical Case Management
Second Surgical Opinion	100% of SCSB	100% of SCSB

Coverage Levels (continued)

Description	Benefit When Using A Contracted Provider	Benefit When Using A Non-Contracted Provider
Skilled Nursing Facility (SNF), non-custodial	90% of SCSB Requires Pre-authorization and Medical Case Management	70% of SCSB after Deductible Requires Pre-authorization and Medical Case Management
Sleep Studies	90% of SCSB, up to \$2,000 maximum in a 3-year period	70% of SCSB after Deductible, up to \$2,000 maximum in a 3-year period
Speech Therapy	100% of SCSB after applicable office Copayment per visit. Lifetime Maximum of 60 visits (must meet criteria to be Eligible)	70% of SCSB after Deductible. Lifetime Maximum of 60 visits (must meet criteria to be Eligible)
Substance Abuse Treatment	Requires Pre-authorization through Mental Health Care of Utah (MHCU) at 1-800-541-9432	
<i>Inpatient Hospital</i>	50% of SCSB	Non-covered
<i>Inpatient Physician Visits</i>	50% of SCSB	Non-covered
<i>Outpatient Therapy</i>	100% of SCSB after applicable office Copayment per visit	Non-covered
Surgery, Physician		
<i>Inpatient or Outpatient Facility</i>	90% of SCSB	70% of SCSB after Deductible
<i>Physician's Office</i>	100% of SCSB after applicable office Copayment per visit	70% of SCSB after Deductible
Take Home Medications	80% of SCSB	70% of SCSB after Deductible
Temporomandibular Joint Dysfunction (TMJ, TMD)	50% of SCSB, Limited to a \$1,000 Lifetime Maximum	50% of SCSB after Deductible Limited to a \$1,000 Lifetime Maximum
Transplants	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)
Urgent Care Facility	100% of SCSB after \$30 Copayment per visit	70% of SCSB after Deductible