MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Annual Medical Deductible (includes pharmacy) **Deductible must be met individually for Single Coverage or cumulatively for Double or Family Coverage before any benefits apply.**	**$2,000 Single $4,000 Double or Family**	**$4,000 Single $8,000 Double or Family**
	You are responsible for 100% of the discounted costs of eligible medical and pharmacy charges until you meet the separate in-network plan year deductible before the plan will pay any benefits	**You are responsible for 100% of the costs of eligible medical and pharmacy charges until you meet the separate out-of-network plan year deductible before the plan will pay any benefits**
City's Health Savings Account (HSA) Contribution (or HRA if not eligible for the HSA)	**$1,000 Single $2,000 Double or Family**	
Out-of-Pocket Maximum** *Any one individual may not apply more than $8,000 toward the in-network family Out-of-Pocket Maximum. Deductible applies to the Out-of-Pocket Maximum.*	**$4,000 Single $8,000 Double or Family**	**$8,000 Single $16,000 Double or Family**
	All qualified medical and pharmacy services do apply to the out-of-pocket maximum	**All qualified medical and pharmacy services up to the PEHP Allowed Amount (AA) apply to the out-of-pocket maximum 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. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.**
Lifetime Maximum	**No Lifetime Maximum**	**No Lifetime Maximum**
PEHP Value Providers *Cash Back opportunities available. See www.pehp.org/valueproviders*	**90% after deductible**	**Not applicable**

AA = Allowed Amount

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

**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. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.*

**PEHP tracks overall out-of-pocket spending to assure it doesn't exceed the IRS-defined, overall out-of-pocket maximum. PEHP refers to the Master Policy for exceptions to the out-of-pocket maximum.

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Acupuncture *20 visits maximum per plan year. 30 minutes per visit*	90% of AA after deductible	70% of AA after deductible Member pays balance
Adoption / Assisted Reproductive Technology (ART) *$4,000 maximum regardless of dual coverage. Excludes multiple-embryo ART implants.*	90% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo implant	
Allergy Injections	100% of AA after deductible	80% of AA after deductible Member pays balance
Allergy Serum	100% of AA after deductible	80% of AA after deductible Member pays balance
Ambulance *ground or air*	100% of AA after deductible and $50 copayment per occurrence. Member pays balance	
Ambulatory Surgical Facility	90% of AA after deductible	70% of AA after deductible Member pays balance
Anesthesia	90% of AA after deductible	70% of AA after deductible Member pays balance
Assistant Surgeon *AA is 20% of allowable surgical fee or 10% for a PA or RN assistant*	90% of AA after deductible	70% of AA after deductible Member pays balance
Autism	Primary Care: 100% of AA after deductible and $25 copayment per visit Specialist: 100% of AA after deductible and $35 copayment per visit	80% of AA after deductible Member pays balance
Bariatric Surgery ***Requires*** *Preauthorization by calling 801-366-7755. Specific providers only.*	90% of AA after deductible	No coverage Must use in-network provider
Cardiac Rehabilitation *Phase 2*	100% of AA after deductible and $35 copayment per visit, up to 24 visits allowed per plan year	80% of AA after deductible, up to 24 visits allowed per plan year Member pays balance
Chemotherapy		
Outpatient Facility	90% of AA after deductible	70% of AA after deductible Member pays balance

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
*Home (**Requires** Preauthorization by calling 801-366-7555)*	90% of AA after deductible	70% of AA after deductible Member pays balance
Chiropractic Therapy	100% of AA after deductible and $35 copayment per visit, up to 20 visits per plan year	No coverage Must use in-network provider
Dental Accident or Certain Medical Conditions *(**Requires** Preauthorization by calling 801-366-7555)*	90% of AA after deductible	90% of AA after deductible Member pays balance
Diabetes Education *Must have the diagnosis of diabetes.*	100% of AA after deductible and applicable office copayment per visit	80% of AA after deductible Member pays balance
Diagnostic Radiology		
Inpatient Facility	90% of AA after deductible	70% of AA after deductible Member pays balance
Outpatient Facility	100% of AA after deductible for each service up to $350 80% of AA after deductible for each service more than $350	80% of AA after deductible Member pays balance
Inpatient/Outpatient Physician	100% of AA after deductible for each service up to $350 80% of AA after deductible for each service more than $350	80% of AA after deductible Member pays balance
MRI	100% of AA after deductible for each service up to $350 80% of AA after deductible for each service more than $350	80% of AA after deductible Member pays balance
3D Mammogram	100% of AA after deductible for each service up to $350 80% of AA after deductible for each service more than $350	80% of AA after deductible Member pays balance
Diagnostic Testing/Laboratory		
Inpatient Facility	90% of AA after deductible	70% of AA after deductible Member pays balance
Outpatient Facility	100% of AA after deductible for each test up to $350 80% of AA after deductible for each test more than $350	80% of AA after deductible Member pays balance
Inpatient/Outpatient Physician	100% of AA after deductible for each test up to $350 80% of AA after deductible for each test more than $350	80% of AA after deductible Member pays balance

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Dialysis *Outpatient facility*	90% of AA after deductible	70% of AA after deductible Member pays balance Requires Preauthorization by calling 801-366-7555
Home *(**Requires** Preauthorization by calling 801-366-7555)*	90% of AA after deductible	70% of AA after deductible Member pays balance
Emergency Room		
Facility *(Copayment applies to each visit, including follow-up visits; copayment waived if admitted)*	100% of AA after deductible and $150 copayment per visit	100% of AA after deductible and $150 copayment per visit Member pays balance
Physician	100% of AA after deductible	100% of AA after deductible Member pays balance
Specialist	100% of AA after deductible and $35 copayment per visit	100% of AA after deductible and $35 copayment per visit Member pays balance
Functional Reconstructive Surgery ***Requires** Preauthorization by calling 801-366-7555*	90% of AA after deductible	70% of AA after deductible Member pays balance
Hearing		
Hearing Aids ***Requires** Preauthorization by calling 801-366-7755*	90% of AA after deductible, up to $1,500 per ear every five years	
Hearing Tests *(When not associated with hearing aids)*	100% of AA after deductible	100% of AA after deductible Member pays balance
Home Health Care	All services require Preauthorization. Call PEHP at 801-366-7555 for information	
Skilled Nursing *60-visit limit per plan year*	100% of AA after deductible	80% of AA after deductible Member pays balance
IV Therapy (antibiotics)	100% of AA after deductible	80% of AA after deductible Member pays balance
Chemotherapy, Dialysis	90% of AA after deductible	70% of AA after deductible Member pays balance
Physical, Occupational, Speech Therapy	100% of AA after deductible and $35 copayment per visit Maximum limits apply	80% of AA after deductible Maximum limits apply Member pays balance
Total Parenteral Nutrition (TPN)	80% of AA after deductible	80% of AA after deductible Member pays balance
Enteral (Tube) Feeding Supplies	80% of AA after deductible	80% of AA after deductible Member pays balance
Enteral Formula	If approved, must be obtained through the pharmacy card	If approved, must be obtained through the pharmacy card

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Hospice Services	**100% of AA after deductible**	**80% of AA after deductible Member pays balance**
Hospital		
Inpatient ***Requires*** *All out-of-network facilities and some in-network facilities require preauthorization by calling 801-366-7755. See Master Policy for details*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Outpatient	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Physician Visits	**100% of AA after deductible and applicable office copayment per visit**	**80% of AA after deductible Member pays balance**
Hyperbaric Oxygen Treatment ***Requires*** *Preauthorization by calling 801-366-7555*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Infertility *(medical) (See limitations in the Master Policy.)*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Injections **Refer to the prescription drug section for Specialty Injections.**		
$50 and under	**100% of AA after deductible**	**80% of AA after deductible Member pays balance**
Over $50	**80% of AA after deductible**	**80% of AA after deductible Member pays balance**
Jaw		
Jaw Surgery ***Requires*** *Preauthorization by calling 801-366-7555*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Temporomandibular Joint Dysfunction (TMJ/TMD) *Diagnosis and Treatment excluding surgery* *(See Master Policy for Covered Services and Limitations)*	**90% of AA after deductible Limited to a combined lifetime benefit of $1,000**	**70% of AA after deductible Member pays balance Limited to a combined lifetime benefit of $1,000**

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Medical Equipment *(Durable Medical Equipment)*	**Certain DME requires Preauthorization by calling 801-366-7555**	
General	**80% of AA after deductible**	**80% of AA after deductible Member pays balance**
Breast Pump *Hospital-grade requires Preauthorization by calling 801-366-7555.*	**100% of AA before deductible**	**80% of AA after deductible Member pays balance**
Knee Braces *(See Limitations in the Master Policy)*	**80% of AA after deductible 1 custom brace or 1 off the shelf brace per knee in a 3 year period**	**80% of AA after deductible 1 custom brace or 1 off the shelf brace per knee in a 3 year period**
Oxygen *Machine rental only*	**80% of AA after deductible**	**80% of AA after deductible Member pays balance**
Sleep Disorder	**80% of AA after deductible. Machine purchase limited to one per 5-year period. Supplies limited to $325 per plan year**	**80% of AA after deductible. Machine purchase limited to one per 5-year period. Supplies limited to $325 per plan year**
Wheelchairs (including parts and replacements) *(See Limitations in the Master Policy)*	**80% of AA after deductible 1 power wheelchair in a 5-year period**	**80% of AA after deductible 1 power wheelchair in a 5-year period. Member pays balance**
Medical Travel *Out of Country Services through Passport for Health vendor. Contact PEHP for details*	**100% of AA after deductible**	**Not applicable**
Mental Healthcare/Substance Abuse/Pain Treatment/PTSD		
Mental Healthcare, Substance Abuse and Pain Treatment *Inpatient Hospital* ***Requires** Preauthorization by calling PEHP at 801-366-7755*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Residential Treatment ***Requires** Preauthorization by calling PEHP at 801-366-7755* *Up to 60 days per plan year*	**90% of AA after deductible**	**70% of AA after deductible Member pays balance**
Mental Healthcare and Substance Abuse Inpatient Physician Visits	**100% of AA after deductible and applicable office copayment per visit**	**70% of AA after deductible Member pays balance**
Mental Healthcare and Substance Abuse Outpatient Therapy	**100% of AA after deductible and $35 copayment per visit**	**70% of AA after deductible Member pays balance**

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Pain Treatment Outpatient Facility/Surgical Suite	90% of AA after deductible	70% of AA after deductible Member pays balance
Pain Treatment All services related to: Trigger Point, Sacroiliac Joint, Nerve Block, Epidural Steroid and/or Facet Injections	90% of AA after deductible	70% of AA after deductible Member pays balance
Neuro-psychiatric Testing	100% of AA after deductible for each test up to $350. 80% of AA after deductible for each test more than $350	80% of AA after deductible Member pays balance
Office Visits		
Employee Midtown Clinic	100% of AA after deductible and $10 copayment per visit	Not applicable
Primary Care Provider	100% of AA after deductible and $25 copayment per visit	80% of AA after deductible Member pays balance
Specialist	100% of AA after deductible and $35 copayment per visit	80% of AA after deductible Member pays balance
Urgent Care Provider	100% of AA after deductible and $45 copayment per visit	80% of AA after deductible Member pays balance
Out-of-State Coverage	For out-of-state providers, visit www.pehp.org or refer to your PEHP ID card. See the Master Policy for more information.	
Pain Clinics/Treatment (Refer to Mental Health)		
Physical Therapy/ Occupational Therapy *Outpatient/Office* *Up to 20 combined visits per plan year. No Preauthorization required*	100% of AA after deductible and $35 copayment per visit	80% of AA after deductible Member pays balance
Prescription Drugs *Subject to deductible*	Refills at retail and/or home delivery are not payable until 75% 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 in brand name cost. The difference does not apply to the deductible or out-of-pocket maximum.	
Retail *(Some medications available up to 90-day supply at retail for the home delivery co-pay)*		
Tier 1	$10 copayment after deductible	Plan pays up to the discounted cost, minus the applicable copayment after deductible. Member pays any balance
Tier 2	Member pays 25% of discounted cost after deductible. $25 minimum copayment $75 maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment after deductible. Member pays any balance
Tier 3	Member pays 50% of discounted cost after deductible. $50 minimum copayment $100 maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment after deductible. Member pays any balance

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Home Delivery *(90-day supply)*		
90-day prescription (Maintenance medications only)	<u>Administered by Express Scripts</u> Prescription drugs can be obtained in one of two ways: • By Fax—Member should ask their doctor to prescribe maintenance medications for a 90-day supply, plus refills if appropriate. The doctor should call 1-888-327-9791 for instructions on how to fax the prescription. Member should provide the doctor with their member ID number. (Note: Only a doctor's office may fax the prescription.) Member will be billed for the copayment. • Home Delivery—Member should ask their doctor to prescribe needed medications for a 90-day supply, plus refills if appropriate. Member should then mail the prescription and the applicable copayment in the special order envelope to Express Scripts. Special order envelopes can be obtained from PEHP. Your copayment amount can be obtained by calling 1-800-903-4725. Member may pay by check, money order, HSA card, FLEX$ card, or credit card (MasterCard, Visa or Discover). Allow 14 days for delivery. More information can be obtained through Express Scripts' website at www.express-scripts.com.	
Tier 1	$20 copayment after deductible	Not applicable
Tier 2	Member pays 25% of discounted cost after deductible. $50 minimum copayment $150 maximum copayment	Not applicable
Tier 3	Member pays 50% of discounted cost after deductible. $100 minimum copayment $200 maximum copayment	Not applicable
Specialty drugs May require preauthorization		
Retail Pharmacy *PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage. Call the PEHP Pharmacy Department at 1-801-366-7551*	**Tier A:** Member pays 20% of AA after deductible, no maximum copayment **Tier B:** Member pays 30% of AA after deductible, no maximum copayment	Plan pays up to the discounted cost, minus the preferred copayment, if applicable, after deductible. Member pays any balance

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Through specialty vendor Accredo	**Tier A:** Member pays 20% of AA after deductible, $150 maximum copayment **Tier B:** Member pays 30% of AA after deductible, $225 maximum copayment **Tier C1:** 10%. of AA after deductible, no maximum co-pay **Tier C2:** 20%. of AA after deductible, no maximum co-pay **Tier C3:** 30%. of AA after deductible, no maximum co-pay	No Coverage Must use in-network provider
	Remember to use Accredo for the lowest possible copayment for your specialty medications. There are some medications that are not able to be dispensed through the Accredo pharmacy. In those cases, your regular specialty medication office visit benefits will apply. Call Accredo at 1-800-803-2523. You can also visit www.accredohealth.com *PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage. Call the PEHP Pharmacy Department at 1-801-366-7551*	
Office/Outpatient *PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage. Call the PEHP Pharmacy Department at 1-801-366-7551*	**Tier A:** Member pays 20% of AA after deductible, no maximum copayment **Tier B:** Member pays 30% of AA after deductible, no maximum copayment	**Tier A:** Member pays 40% of AA after deductible, no maximum copayment. Member pays any balance **Tier B:** Member pays 50% of AA after deductible, no maximum copayment. Member pays any balance
Other Prescription Benefits		
Diabetic Supplies *Free meters — Call the PEHP Pharmacy Department at 1-801-366-7551*	**Paid at the prescription benefit level (includes items such as testing strips, needles, and lancets)**	
Enterals ***Requires** Preauthorization by calling 801-366-7551*	**80% of discounted cost after deductible**	**Not covered**
Food Supplements ***Requires** Preauthorization by calling 801-366-7555*	**80% of discounted cost after deductible. Not covered, except as required for Phenylketonuria (PKU)**	**Not covered**
Foreign Country Medications	**Urgent and emergent medications will be covered if obtained outside the United States when the drug or class of medication is covered under the PEHP Pharmacy or Injectable benefit.**	
Smoking Cessation Medications	**Contact PEHP Pharmacy Customer Service at 801-366-7551 for details**	
Pharmacy Travel Benefits	**Contact PEHP Pharmacy Customer Service at 801-366-7551 for details**	
Prosthetics ***Requires** Preauthorization by calling 801-366-7555*	**80% of AA after deductible** **1 per limb in a 5-year period**	**80% of AA after deductible.** **1 per limb in a 5-year period.** **Member pays balance**

AA = Allowed Amount

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Preventive Services	***You DO NOT have to meet your deductible before your plan pays benefits for these services***	
Affordable Care Act (ACA) *See Master Policy for complete list*	**100% of AA**	**100% of AA** **Member pays balance**
Child *Well Child Exams (Includes routine tests)*	**100% of AA**	**100% of AA** **Member pays balance**
Adult *Annual routine physical (Includes routine tests)*	**100% of AA**	**100% of AA** **Member pays balance**
Routine Annual Immunizations	**100% of AA**	**100% of AA** **Member pays balance**
*Colonoscopy*** *(1 per plan year regardless of age or diagnosis in addition to ACA)*	**100% of AA**	**100% of AA** **Member pays balance**
Mammogram (1 per plan year regardless of age or diagnosis in addition to ACA. Includes 3D)	**100% of AA**	**100% of AA** **Member pays balance**
Annual Vision Exam (1 per plan year. Includes prescription for glasses and contacts)	**100% of AA**	**100% of AA** **Member pays balance**
Dexa Scan (Bone Density-1 per plan year regardless of age or diagnosis in addition to ACA)	**100% of AA**	**100% of AA** **Member pays balance**
Eyewear	**No coverage, refer to PEHPplus for discounts**	
Pulmonary Rehabilitation *Phase 2* *Up to 24 visits per plan year*	**100% of AA after deductible and applicable office copayment per visit**	**80% of AA after deductible** **Member pays balance**
Radiation Therapy	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Rehabilitation *Inpatient* *Up to 45 days per plan year.* ***Requires*** *Preauthorization by calling 801-366-7755*	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**

AA = Allowed Amount

***How to Avoid Colonoscopy Billing Problems: Moderate (conscious) sedation is included and covered when you get a colonoscopy. However, some doctors and facilities will try and bill sedation separately (Propofol for example) in addition to what is normally covered with a colonoscopy. **It is important to check with your doctor or facility PRIOR TO YOUR COLONOSCOPY to see how sedation will be billed.** To avoid excess charges make sure the sedation is included with your colonoscopy. More complex anesthesia must be preauthorized. General anesthesia or Monitored Anesthesia Care (MAC) also requires preauthorization and must be medically necessary.

MEDICAL PLAN OVERVIEW

Benefits	Summit STAR HSA (HDHP)	
	In-Network Provider	Out-of-Network Provider*
Second Surgical Opinion	**100% of AA after deductible**	**100% of AA after deductible** **Member pays balance**
Skilled Nursing Facility (SNF) *Non-custodial* *Limited to 60 days per plan year.* ***Requires*** *Preauthorization by calling 801-366-7755*	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Sleep Studies	**Home and Facility combined maximum, up to $2,000 in a 3-year period.**	
Home	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Facility ***Requires*** *Preauthorization by calling 801-366-7755 when services performed in a facility or attended by a technician*	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Speech Therapy *Lifetime maximum of 60 visits*	**100% of AA after deductible and $35 copayment per visit**	**80% of AA after deductible** **Member pays balance**
Substance Abuse (Refer to Mental Health)		
Surgery, Physician		
Inpatient or Outpatient Facility	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Physician's Office	**100% of AA after deductible and applicable office copayment per visit**	**80% of AA after deductible** **Member pays balance**
Treatment to Affirm Gender Identity		
Mental Health	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Pharmacy	**Refer to prescription drug benefit**	**Refer to prescription drug benefit**
Surgery ***Requires*** *Preauthorization by calling 801-366-7755*	**90% of AA after deductible**	**70% of AA after deductible** **Member pays balance**
Transplants (includes donor typing)	**Payable at applicable benefit level per service rendered** **Requires Preauthorization by calling 801-366-7755 (See Master Policy for limitations and eligibility)**	**Payable at applicable benefit level per service rendered. Member pays balance** **Requires Preauthorization by calling 801-366-7755 (See Master Policy for limitations and eligibility)**
Urgent Care Facility	**100% of AA after deductible and $45 copayment per visit**	**80% of AA after deductible** **Member pays balance**

AA = Allowed Amount

DENTAL PLAN OVERVIEW

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.

INR = In-Network Rate

	Preferred Choice		Premium Choice	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS				
Deductible *Does not apply to Diagnostic & Preventive Services*	None	None	None	None
Annual Benefit Maximum	$1,500	$1,500	$2,000	$2,000
DIAGNOSTIC				
Periodic Oral Examinations	100% of INR	80% of INR	100% of INR	80% of INR
X-rays	100% of INR	80% of INR	100% of INR	80% of INR
PREVENTIVE				
Cleanings and Fluoride Solutions	100% of INR	80% of INR	100% of INR	80% of INR
Sealants | *Permanent molars only through age 17*	100% of INR	80% of INR	100% of INR	80% of INR
RESTORATIVE | *18 months per surface*				
Amalgam Restoration	80% of INR	60% of INR	80% of INR	60% of INR
Composite Restoration	80% of INR	60% of INR	80% of INR	60% of INR
ENDODONTICS				
Pulpotomy	80% of INR	60% of INR	80% of INR	60% of INR
Root Canal	80% of INR	60% of INR	80% of INR	60% of INR
PERIODONTICS				
Periodontal/Gum Disease	80% of INR	60% of INR	80% of INR	60% of INR
ORAL SURGERY				
Extractions	80% of INR	60% of INR	80% of INR	60% of INR
ANESTHESIA				
General Anesthesia *in conjunction with oral surgery or impacted teeth only*	80% of INR	60% of INR	80% of INR	60% of INR
PROSTHODONTIC BENEFITS | *Once every 5 years. Preauthorization may be required*				
Crowns	50% of INR	30% of INR	60% of INR	40% of INR
Bridges	50% of INR	30% of INR	60% of INR	40% of INR
Dentures (partial)	50% of INR	30% of INR	60% of INR	40% of INR
Dentures (full)	50% of INR	30% of INR	60% of INR	40% of INR
IMPLANTS				
All related services	50% of INR	30% of INR	60% of INR	40% of INR

ORTHODONTIC BENEFITS | 6-month Waiting Period				
Maximum Lifetime Benefit per member | *No age limit*	$1,500		$1,500	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum		50% of eligible fees to plan maximum	

Treatment in progress - Payment cannot be made for any procedure started prior to the date the Member became eligible or prior to the effective date of the group contract.

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP. Learn more in the Dental Master Policy. If coverage is provided by a PEHP medical plan, then there is no dental plan coverage.