Effective July 1, 2024 – June 30, 2025

Enrollment Guide

Tooele City

Look inside for important information about how to use your PEHP benefits.

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

Welcome to PEHP

We want to make accessing and understanding your healthcare benefits simple. 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 a PEHP for Members 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

PEHP FLEX$

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

HEALTH SAVINGS ACCOUNTS (HSA)

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

WELLNESS AND DISEASE MANAGEMENT

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

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

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

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

VALUE-ADDED BENEFITS

» PEHPplus ..... https://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

PEHP Summit Exclusive Medical Network

CommonSpirit (Holy Cross), **MountainStar**, and **University of Utah Health Care** providers and facilities.

Participating Hospitals

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital
- Brigham City Community Hospital

Cache County
- Cache Valley Hospital
- Logan Regional Hospital

Carbon County
- Castleview Hospital

Davis County
- Holy Cross Hospital - Davis
- Lakeview Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Cedar City Hospital

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Hospital
- Fillmore Community Hospital

Salt Lake County
- Holy Cross Hospital - Jordan Valley
- Holy Cross Hospital - Jordan Valley West
- Holy Cross Hospital - Salt Lake

Salt Lake County (cont.)
- Huntsman Cancer Hospital
- Lone Peak Hospital
- Primary Children's Medical Center
- Riverton Children's Unit
- St. Marks Hospital
- University of Utah Hospital
- University Orthopaedic Center

San Juan County
- Blue Mountain Hospital
- San Juan Hospital

Sanpete County
- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County
- Sevier Valley Hospital

Summit County
- Park City Medical Center

Tooele County
- Mountain West Medical Center

Uintah County
- Ashley Regional Medical Center

Utah County
- Holy Cross Hospital - Mountain Point
- Mountain View Hospital
- Timpanogos Regional Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- St. George Regional Medical Center

Weber County
- Ogden Regional Medical Center

Non-Contracted Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit. Find participating providers at www.pehp.org/noncoveredproviders.

PEHP Health & Benefits

Traditional Option 4

Summit Exclusive

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $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: $6,000 Double/family plans: $6,000 per person, $12,000 per family *One person cannot meet more than $6,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
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*	$30 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$40 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$40 co-pay per visit	$40 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% 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 / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No 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 / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No 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 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.

Medical Benefits: Traditional Plan Option 4

	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	20% after deductible	40% after deductible
Urgent Care Facility	$50 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit	$150 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	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% 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*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible

Medical Benefits: Traditional Plan Option 4

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *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	20% after deductible	40% 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*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge	40% after deductible
Home Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Health & Benefits

Traditional Option 5

Summit Exclusive

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,500 Double/family plans: $1,500 per person, $3,000 per family *One person cannot meet more than $1,500*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	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	40% after deductible
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*	$35 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$45 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$45 co-pay per visit	$45 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% 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 / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No 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 / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No 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 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.

Medical Benefits: Traditional Plan Option 5

	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	20% after deductible	40% after deductible
Urgent Care Facility	$55 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$225 co-pay after deductible per visit	$225 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	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% 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*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible

Medical Benefits: Traditional Plan Option 5

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *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	20% after deductible	40% 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*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge	40% after deductible
Home Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible	40% after deductible

PEHP Health & Benefits

STAR HSA

Summit Exclusive

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,500 Double/family plans: $5,000 *One person or a combination can meet the $5,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $5,000 Double/family plans: $10,000 *One person can only meet $8,150, or a combination can meet the $10,000 double/family 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	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No 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 / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No 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 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.

	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%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. 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	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	20% after deductible	40% after deductible
Mental Health & Substance Abuse	20% 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*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	40% after deductible

Medical Benefits: STAR HSA Plan

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

Understanding The PEHP STAR Plan

The STAR Plan: What Is It?

The STAR Plan has two components: 1) A High Deductible Health Plan (HDHP), which is a qualified medical plan that meets IRS guidelines for deductibles and out-of-pocket maximums; and 2) a Health Savings Account (HSA), which is an interest-bearing account designed to be coupled with an HDHP.

Do You Qualify?

To be eligible, you must enroll in The STAR Plan. Also, the following things must apply to you:

- You're not participating in or covered by a general-purpose flex account (FSA) or Health Reimbursement Account (HRA) or their balances will be $0 on or before the end of your plan year.
- You're not covered by another health plan (unless it's another HSA-qualified plan).
- You're not covered by Medicare, Tricare or Medicaid.
- You're not a dependent of another taxpayer.

How It Works

YOUR HSA

A Health Savings Account is a tax-advantaged, interest-bearing account.

Your money goes in tax-free, grows tax-free, and is spent on qualified health expenses tax-free.

It's a great way to save for health expenses in both the short and long term.

An HSA is like a flexible spending account, but better. You never have to worry about forfeiting HSA money you don't spend.

Money in your HSA carries over from year-to-year and even from employer-to-employer.

YOUR DEDUCTIBLE

Your deductible is the yearly dollar amount you must pay out of your own pocket for eligible medical and pharmacy expenses **before** PEHP begins paying benefits. The STAR Plan's deductible is set higher than Advantage and Summit Care's.

Eligible Expenses

Eligible HSA expenses include deductibles, copayments, and coinsurance, as well as all flex-eligible health expenses. However, while many expenses are HSA-eligible, they apply to your deductible and out-of-pocket maximum only if they're covered by your health plan.

Debit Card

You'll be automatically issued a debit card to access your HSA funds. Always present your PEHP card at the time of service to receive PEHP's discounted rate. It also allows PEHP to track your spending to apply to your deductible and out-of-pocket maximum.

Some of PEHP's Exclusive Benefits

On-Demand Doctors

See a doctor via mobile or web with discounted pricing through Intermountain Connect Care. It's available 24 hours a day, every day, without an appointment.

PEHP Value Providers

Make one of these full-service providers your family doctor and save! They provide all the services of a family doctor, but at a lower cost.

Wellness For You

PEHP offers programs, tools, and resources to help you take control of your health, including Healthy Utah Testing Sessions. Learn more at www.pehp.org/wellness

New Prescription Cost Tool

Find drug options for your health condition, compare prices at different pharmacies, and see if cash back is available for your medication. Learn more at www.pehp.org/save

Get Up to $2,000 in Cash Back

Share in the savings when you choose a lower-cost provider. Find out about cash back services using PEHP's Cost Tools. Look for the green phone with a dollar sign.

Pharmacy Resources

Find PEHP's Covered Drug List, learn which medications require preauthorization, find information about savings programs and many more resources on PEHP's pharmacy page.

Mental Health Care & Resources

Your PEHP mental health benefit covers treatment for specific mental health conditions.

Seeking Reimbursement for Cash Payments

If you pay for your covered medical service in full, you can get reimbursed or get credited towards your deductible. Find the reimbursement form at www.pehp.org under *Resources & Help > Find a Form > Self-Pay Medical Claim Form*.

Reimbursement for Pharmacy Cash Payments

If you pay for your covered prescription in full, you can get reimbursed or get credited towards your deductible. Find the reimbursement form at www.pehp.org/pharmacy/cob

PEHP Pays for Preventive Services

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider — even before you meet your deductible. Learn more at www.pehp.org/preventive services

Autism Spectrum Disorder Benefit

The benefit covers behavioral health treatment (ABA Therapy).

A brief overview of PEHP's Autism Spectrum Disorder coverage:

» Please call PEHP (801-366-7555 or 800-765-7347) for information about which autism spectrum disorders and services are covered.

» Therapeutic care includes services provided by speech therapists, occupational therapists, or physical therapists.

» Eligible Autism Spectrum Disorder services do not accrue separately, and are subject to the medical plan's visit limits, regular cost sharing limitations – deductibles, co-payments, and coinsurance – and would apply to the out-of-pocket maximum.

» Mental health and speech therapy services require Preauthorization.

» No benefits for services received from out-of-network Providers. List of in-network providers is available through your **PEHP account** or by calling PEHP (801-366-7555 or 800-765-7347).

» Regular medical benefits will apply (see benefits grid for applicable co-pay and coinsurance).

Need Immediate Care? Consult a Doctor Remotely

A Fast, Easy Way to See a Doctor

Families have access to care for urgent, low-level needs such as:

» Eye infections
» Painful urination
» Joint pain or strains
» Minor skin problems

Intermountain Connect Care

Available 24/7/365 (even on holidays)

» Summit
» Advantage
» Preferred

University of Utah Health Virtual Visits

Available 9 a.m.-9 p.m., 7 days a week

» Summit
» Preferred
» Capital

If You're on the Traditional Plan

Each on-demand doctor consultation costs only a **$10 co-pay**.

If You're on the STAR HSA Plan

Each on-demand doctor consultation costs only **$69** before you meet your deductible (**$49** for UofU virtual visits). After your deductible is met, you pay only a **$10 co-pay**.

Download the Intermountain Connect Care app from the **Google Play Store** or **iTunes App Store**.

GET IT ON Google Play Download on the App Store

For UofU Health Virtual Visits, go to **healthcare.utah.edu/virtual-care/virtual-visits/**

PEHP Health & Benefits

YOU'RE COVERED

PEHP Pays for **Preventive Benefits** at 100%*

Don't put off that test or immunization. Preventive benefits are covered at no cost to you when you see a contracted provider — even before you meet your deductible.

Covered Preventive Services for Adults

(Ages 18 and older)

» Preventive physical exam visits for adults, one time per plan year including:
  › Blood pressure screening
  › Basic/comprehensive metabolic panel
  › Complete blood count
  › Urinalysis
» Abdominal aortic aneurysm one-time screening for men aged 65-75 who have ever smoked.
» Alcohol misuse screening and counseling.
» Aspirin use for men ages 45-79 and women ages 55-79, covered under the pharmacy benefit when prescribed by a physician.
» Cholesterol screening for adults of certain ages or at higher risk.
» Colorectal cancer screening for adults ages 45 to 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
PEHP covers Conscious Moderate Sedation for colon screenings. If you don't have an ASA score of P3 or higher, or a Mallampati score of III or higher, General Anesthesia or Monitored Anesthesia Care is not covered for those providers that bill separately for it. Check with your doctor to find out if you meet these requirements.
» Depression screening for adults.
» Type 2 diabetes screening for adults with high blood pressure.
» Diet counseling for adults at higher risk for chronic disease including hyperlipidemia, obesity, diabetes, and cardiovascular disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists including registered dietitians.
» HIV screening for all adults at higher risk.
» Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  › Hepatitis A
  › Hepatitis B
  › Herpes zoster (shingles age 50 and above)
  › Human papillomavirus (HPV)
    » males age 9-21 Gardasil
    » females age 9-26 Gardasil or Cervarix
  › Influenza (flu shot)
  › Measles, mumps, rubella
  › Meningococcal (meningitis)
  › Pneumococcal (pneumonia)
  › Respiratory syncytial virus (RSV)
    » all adults 60+ Abrysvo
    » pregnant women Abrysvo, one time per plan year
  › Tetanus, diphtheria, pertussis (Td or Tdap)
  › Varicella (chickenpox)

Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.

» Obesity screening and counseling for all adults by primary care clinicians to promote sustained weight loss for obese adults.
» Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
» Tobacco use screening for all adults and cessation interventions for tobacco users.
» Syphilis screening for all adults at higher risk.

Covered Preventive Services Specifically for Women, Including Pregnant Women

» Preventive gynecological exam, two per plan year.
» Anemia screening on a routine basis for pregnant women.
» Bacteriuria urinary tract or other infection screening for pregnant women.
» BRCA counseling about genetic testing for women at higher risk.
» BRCA testing for women at higher risk, requires preauthorization from PEHP.
» Breast cancer mammography screenings are covered once per plan year for women over 40, and those under 40 who receive preauthorization.
» Breast cancer chemoprevention counseling for women at higher risk.
» Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
» Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
Coverage allows for either a manual or electric breast pump within 12 months after delivery. Hospital grade breast pumps when medically necessary and preauthorized by PEHP are also included.

Continued on back

Preventive Services Coverage

Continued from front

- Cervical cancer screening (pap smear) for women ages 21-65.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
  - Covered services/devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphragms, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant, covered under the pharmacy benefit when prescribed by a physician.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Human immunodeficiency virus (HIV) screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older in conjunction with cervical cancer screening (pap smear).
- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.

Covered Preventive Services Specifically for Children

(Younger than age 18)

- Preventive physical exam visits throughout childhood as recommended by the American Academy of Pediatrics including:
  - Behavioral assessments for children of all ages;
  - Blood pressure screening for children;
  - Developmental screening for children under age 3 and surveillance throughout childhood;
  - Oral health risk assessment for young children;
- Alcohol and drug use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Cervical dysplasia (pap smear) screening for sexually active females.
- Congenital hypothyroidism screening for newborns.
- Depression screening for adolescents.
- Dyslipidemia screening for children at higher risk of lipid disorders.
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns, birth to 90 days old.
- Height, weight, and body mass index measurements for children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, tetanus, pertussis (Dtap);
  - Haemophilus influenzae type b (Hib);
  - Hepatitis A;
  - Hepatitis B;
  - Human papillomavirus (HPV);
    - Males age 9-21 Gardasil;
    - Females age 9-26 Gardasil or Cervarix;
  - Inactivated poliovirus;
  - Influenza (Flu Shot);
  - Measles, mumps, rubella;
  - Meningococcal (meningitis);
  - Pneumococcal (pneumonia);
  - Rotavirus;
  - Varicella (chickenpox).

  Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Obesity screening and counseling.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis.
- Vision screening for all children one time between ages 3 and 5.

Coverage for Specific Drugs

Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over-the-counter purchases are not covered. See applicable Benefits Summary for coverage information.

- Aspirin use for men age 45-79 and women age 55-79.
- Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
- Folic acid supplements for women who may become pregnant.
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Tobacco use cessation interventions, up to the maximum approved dose and duration per plan year.

Additional Preventive Services When Enrolled in The STAR Plan

(doesn't apply to Jordan School District)
(doesn't apply to Consumer Plus)

Adults

- Eye exam, routine. One per plan year.
- Glaucoma screening.
- Glucose test.
- Hearing exam.
- Hypothyroidism screening.
- Phenylketones test.
- Prostate cancer screening.
- PSA (prostate specific antigen) screening.
- Refraction exams.
- Blood typing for pregnant women.
- Rubella screening for all women of child bearing age at their first clinical encounter.

Children

- Eye exam, routine. One per plan year.
- Glaucoma screening.
- Hearing exam.
- Hypothyroidism screening.
- Refraction exams.

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* PEHP processes claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, cost sharing may apply. Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

PEHP FLEX$ Plan Year: July 1, 2024 – June 30, 2025

FLEX$ saves you money by reducing your taxable income. You set aside a portion of your pre-tax salary to pay eligible expenses.

PEHP offers two types of FLEX$: healthcare and dependent day care. Enroll in one or both.

ENROLLMENT

» You must re-enroll for FLEX$ every plan year.

» **Open enrollment**: Enroll online at www.pehp.org. Fill out a paper form and return it to HR.

» **New hires:** Enroll within 60 days of eligibility date.

PLAN YEAR CONTRIBUTION LIMITS

» Up to **$3,200** for healthcare expenses (May adjust annually for inflation).

» Up to **$5,000** for dependent day care expenses (you and your spouse combined).

HOW YOU CONTRIBUTE

» Your contributions are withheld from your paycheck pre-tax. The total amount you contribute is evenly divided among pay periods.

» The total amount you choose to withhold for healthcare expenses is immediately available as soon as you begin FLEX$.

YOU CAN'T HAVE AN HSA WITH FLEX$

You can't contribute to a health savings account (HSA) while you're enrolled in healthcare FLEX$. However, you may have a dependent day care FLEX$ and/or a limited FSA and contribute to an HSA.

OLDER CHILDREN

» Children up to age 26* can remain covered regardless of marital or dependent status.

*(*Up to Dec. 31 of the calendar year they turn age 26.)*

Reminder

You can carry over up to $640 in your healthcare FLEX$ from one plan year to the next. You do not have a grace period for eligible expenses.

FLEX$ Timeline

PLAN YEAR:
July 1, 2024 – June 30, 2025

Eligible FLEX$ expenses must be incurred between July 1, 2024, and June 30, 2025.

You must submit claims by September 30, 2025.

July 1, 2024
2024-25 FLEX$ plan year begins

June 30, 2025
2024-25 FLEX$ plan year ends

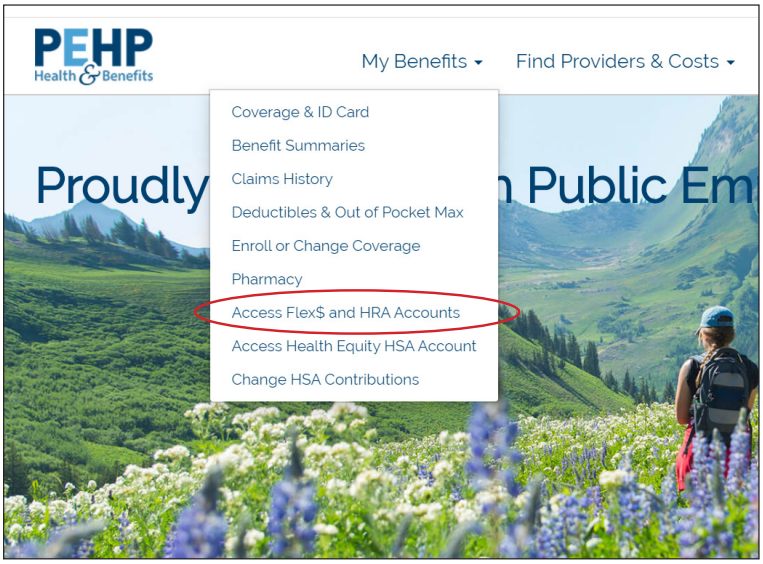
September 30, 2025
Deadline to submit claims

After September 30, 2025
You can carry over up to $640 in your healthcare FLEX$ into the next plan year

PEHP FLEX$ Plan Year: July 1, 2024 – June 30, 2025

Managing FLEX$ Online

Visit www.pehp.org, hover over the "My Benefits" menu header, and select "Access Flex$ and HRA accounts."



Using Your FLEX$ Card

Access your FLEX$ account with the FLEX$ Benefits Card you will automatically receive at no extra cost. It can work just like a credit card or a debit card. The FLEX$ card does not work for Day Care accounts.

The FLEX$ card doesn't always distinguish which purchases are eligible. You're responsible to keep all receipts for tax and verification purposes. PEHP may ask for verification of charges.

For places that don't accept the FLEX$ Benefits Card, simply pay for the charges and submit a copy of the detailed receipt and a claim form to PEHP for reimbursement.

Limitations apply. Go to www.pehp.org for eligibility and more details.

Eligible Expenses

- Most over-the-counter drugs and medicines can be paid for or reimbursed without a doctor's prescription.
- Menstrual care products are now considered a qualified medical expense and are eligible for payment or reimbursement.

FLEX$ HEALTHCARE ACCOUNT for eligible health expenses for you and your eligible dependents. A partial list of eligible expenses is on the back of this brochure.

FLEX$ DEPENDENT DAY CARE ACCOUNT for eligible day care expenses for your eligible dependents to allow you and/or your spouse to work, look for work, or go to school.

For more information about which expenses are eligible, download IRS Publication 502.

PEHP FLEX$ Plan Year: July 1, 2024 – June 30, 2025

What's covered?

Examples of eligible expenses

» Alcohol & drug treatment programs
» Band-Aids, bandages & gauze pads
» Body scan – diagnostic or screening tests
» Cold/hot packs for injuries
» Cold, flu medicine, cough drops & throat lozenges
» Condoms & spermicidal foam
» Contact lenses, including lens care supplies
» Eyeglasses
» First aid cream & antibacterial ointment
» Hand sanitizer
» Hearing aids & batteries
» Infertility treatment
» Laser eye surgery
» Masks (PPE)
» Menstrual care products
» Orthodontia (copy of contract required)
» Orthotics
» Most over-the-counter medications
» Prescription drugs
» Routine physical exams
» Nasal strips
» Sanitizing wipes
» Sunburn ointment or cream
» Thermometers

What's not covered?

Examples of non-eligible expenses

» Aromatherapy
» Botox
» Contact lens service agreement or insurance
» Cosmetic procedures & surgery
» Dental service agreement
» Face cream, suntan lotion & moisturizers
» Health club dues and gym memberships
» Insurance premiums
» Electrolysis or hair removal
» Oral supplies and electric toothbrushes
» Payments for services performed outside the current plan year
» Vitamins and supplements

Examples of expenses requiring a doctor's note

» Massage therapy
» Sunglasses
» Weight loss drugs & programs for treatment of a specific disease

PEHP FLEX$ CONTACT INFO

Phone: 801-366-7503 or 800-753-7703 | **Fax:** 801-366-7772 | **Email:** flex@pehp.org

3-19-24

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

Note: Six month waiting period applies to prosthodontic, implant, and orthodontics benefits unless you show PEHP you were covered by a qualified dental insurance plan for at least six consecutive months before joining PEHP dental.

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 | 6-month Waiting Period		
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	

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 a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

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

PEHP Cost Tools

Find Quality Care & Best Value

Finding quality care at the right place is important. PEHP has several cost comparison tools that help you shop for the best providers and the best value.

To get started, log in to your PEHP account and click "Find Providers & Costs" in the top menu.

Find and Compare Providers

Under the "Find a Provider" tab, you can search for doctors and other healthcare providers in your network, see and compare cost information, and read reviews from other PEHP members. Plus, you can see how often a doctor refers lab work to a costly hospital or lower-cost independent lab.

Find and Compare Healthcare Facilities

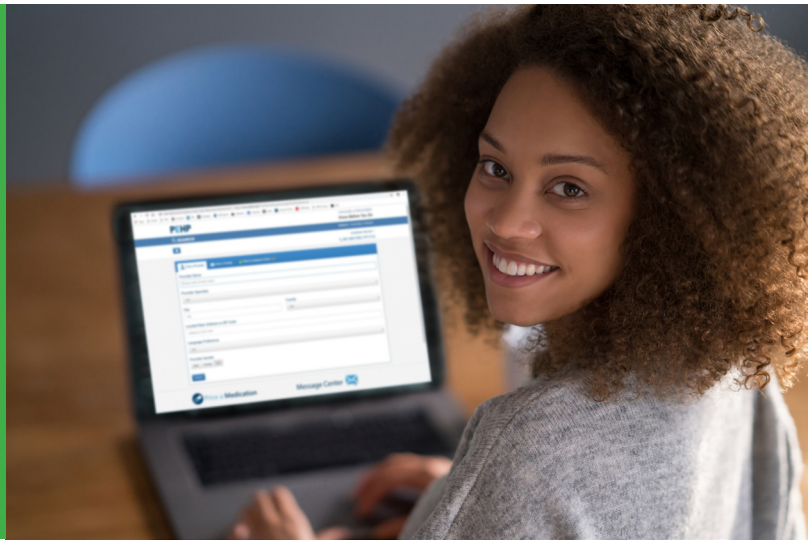
Under the "Find a Facility" tab, you can search for healthcare facilities (e.g. hospitals, clinics, surgical centers) in your network, and see and compare cost information.

Looking for Lower Drug Costs?

Click on "Compare Prescription Costs." You'll see medication prices from different pharmacies, including home delivery, which is often less expensive.

To get the best deal, use medications on lower tiers in the PEHP Covered Drug List – a list of prescription medications available to members at lower costs.

These cost comparison tools are just one way we strive to make healthcare costs transparent, so you decide where to go for the best care and value.



PEHP LTD

Your Reliable Safety Net

PEHP Long-Term Disability (LTD) is your safety net should you become disabled and unable to work. This important benefit is paid for by your employer at no cost to you.

After a three-month waiting period, LTD provides two-thirds of your regular monthly salary for accidental bodily injury, disease, or illness if you're unable to perform your regular job. If you're disabled by external force or violence while performing your job, you may be eligible to receive 100% of your regular salary.

After two years on LTD, if you can't perform any gainful employment, you may apply for "ongoing" LTD. To continue receiving the benefit, you must be unable to perform any gainful employment due to physical disability.

LTD Basics	
Benefit Amount	Two-thirds of your salary
Waiting Period	Three months; closest to the first of the month
First 24 months of LTD	Must be unable to perform your regular job
After 24 months of LTD	Must be unable to perform any gainful employment due to physical disability (includes sedentary work)
Maximum Benefit	Age 65* or retirement with Utah Retirement Systems**
Line of Duty Benefit (External Force/Violence)	100% of regular salary

*Exception is if date of disability is age 60+. See Page 4.

**Go to www.urs.org to find out the years of service required for you to retire.

Learn More About PEHP LTD

Answers to our most frequently asked questions

When should I apply for LTD benefits?
You must apply for LTD benefits within six months from your last day worked in your regular full-duty job.

We encourage you to apply as soon as possible.

How do I apply for LTD benefits?
Contact our office for a phone interview and then you will be mailed an application and other forms to sign. See contact information on the back page.

Who is eligible?
Most employees who are eligible for an employer sponsored retirement plan are eligible for LTD; contact us if you need to confirm your eligibility. The Legislature created the benefit as a bridge from active to retirement status therefore URS post-retirees are ineligible. Retirement is the only benefit available to employees who have accrued full years of service toward retirement because Title 49 states LTD benefits terminate when the eligible employee has accumulated the following years:

Accrued years to retire are:
- Tier 1 Public Employee: 30 years
- Tier 1 Public Safety: 20 years
- Tier 2 Public Employee: 35 years
- Tier 2 Public Safety: 25 years

It is also important to note that age is not a factor in determining initial eligibility; if you're age 60 or older, see the next page.

Vocational Rehabilitation	Services include counseling and assistance returning to your regular job or finding new employment.
Rehabilitative Employment	May be able to work while on LTD. Requires prior approval. LTD benefits partially reduced.
Psychological Care Reimbursement	LTD may reimburse for copays for care while on LTD for psychological reasons. Requires prior approval.

How does PEHP LTD confirm I am disabled?
We must confirm your disability and impairment with objective medical documentation. We do this by collecting and reviewing medical records from your healthcare providers.

What happens to my URS retirement accrual while I am on LTD?

- **If you were hired before July 1, 2011**, you will continue to earn years of service toward your URS retirement.
- **If you were hired on or after July 1, 2011**, you may continue to earn years of service credit toward URS retirement if your employer has signed a benefit protection contract. Check with your employer.

Are there limits to my benefit?
Medical or psychological conditions that existed prior to eligibility may not be a basis for LTD benefits until you have had one year of continuous LTD eligibility.

For disabilities caused by psychological illness, benefits are limited to the first initial 24 months unless you're institutionalized.

How long can I receive LTD benefits?

If you are unable to perform your regular job and you remain disabled, you may remain on disability up to 24 months.

At the end of 24 months, you can apply for ongoing benefits if you can't perform any gainful employment, based on objective medical documentation.

As long as you meet the disability requirements you can remain on LTD until you reach age 65 or have enough years of service toward retirement to retire, whichever comes first.

If you become disabled at or after age 60, LTD is payable as follows (unless you accrue enough years of service toward retirement to retire first):

Age 60 or 61	»	five years
Age 62 or 63	»	four years
Age 64 or 65	»	three years
Age 66, 67 or 68	»	two years
Age 69 or older	»	one year

PEHP
Long-Term Disability

560 East 200 South
Salt Lake City, UT 84102

801-366-7583 | 800-365-7347

Email us: pehp.ltd@pehp.org

More info: visit www.pehp.org

Does other income affect my LTD benefits?

LTD benefits are reduced when you receive income from sources such as Social Security, workers' compensation, third-party payments, sick/vacation pay and wages from rehabilitative employment.

Note: This brochure offers a brief overview only. For more detailed information about your LTD benefits, go to www.pehp.org.

The LTD Program is established by Title 49 of Utah Code at 49-21-101. The information here provides a general description of benefits provided and is for informational purposes only. No error, misrepresentation or ambiguity in this information creates any rights or benefits not expressly granted by Utah Code Title 49.

Choose Your Path to Wellness

Whether you're trying to be more active, improve your eating habits or boost your mental well-being – you can now choose your own path to wellness from a menu of options.

Scan to visit website

You can earn rebates and win monthly and annual prizes when you participate in our programs.

To qualify for the annual prize drawing, you must complete your 10 PEHP wellness activities and accompanying survey by December 9, 2024.

Physical Well-Being

Mental & Emotional Well-Being

Healthy Eating

PEHP
Health & Benefits

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance" or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

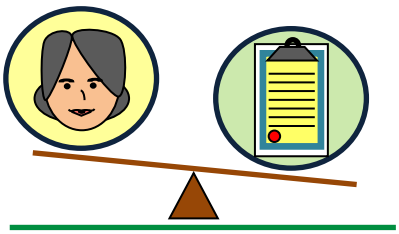
When a provider bills you for the balance remaining on the bill that is not covered by your plan. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. This happens most often when you see an out-of-network provider (non-preferred provider). A preferred provider may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

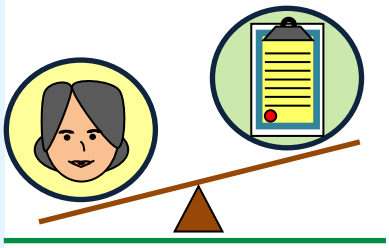
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay or the cost of care a plan doesn't cover usually are not considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you purchase through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following to result: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may place drugs at different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate," the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone and in-person.

Maximum Out-of-Pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value Standard
A basic standard for measuring the percentage of permitted costs covered by the plan . If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, and artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss or a change in the patient's physical condition.

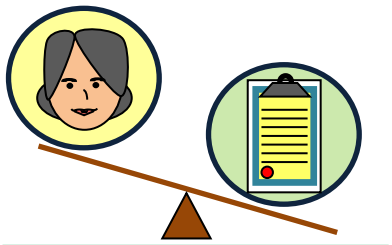
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has special training in a specific area of health care.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

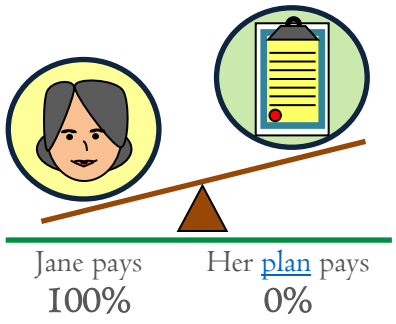
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

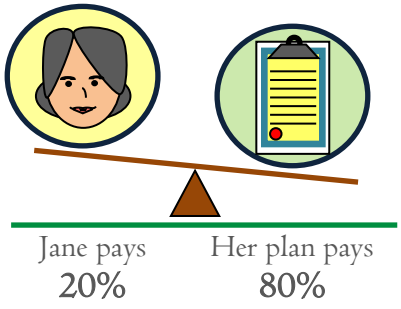
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



more costs



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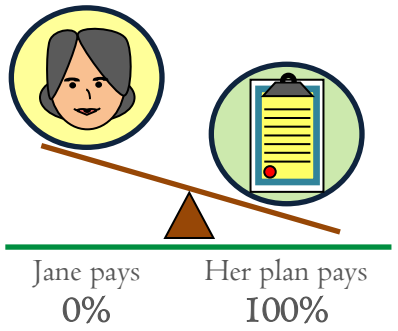

Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pehp.org or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.pehp.org or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Some network provider visits or preventive care received from network providers are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,000** person/**$12,000** family for network providers. No out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit PEHP Value Clinics: Starting at $10 co-pay	40% of Allowed Amount (AA) after deductible	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.
	Specialist visit	$40 co-pay/visit	40% of AA after deductible	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the Allowed Amount (AA) is under $350, 20% of AA after deductible if AA is over $350	40% of AA after deductible	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	No charge if the AA is under $350, 20% of AA after deductible if AA is over $350	40% of AA after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail, $25 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail, $50 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	$150 co-pay after deductible/ visit	$150 co-pay after deductible/visit	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$50 co-pay	40% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	$30/$40 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	40% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$40 co-pay/visit	40% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after deductible	40% of AA after deductible	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	---None---
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge for skilled nursing visit	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	*No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	*Sleep disorder supplies are limited to $325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires pre-authorization.
	Hospice service	No charge	40% of AA after deductible	---None---
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: $40 co-pay per visit.	40% of AA after deductible	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for network providers.
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Developmental delay — screening
- Foot care — routine
- Glasses
- Hearing aids
- Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Coverage provided outside the U.S.
- Dental care (Adults or children)
- Long-term care
- Routine eye care (Adults and children, exams only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711).

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next page.––––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,320
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,320**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pehp.org or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.pehp.org or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Some network provider visits or preventive care received from network providers are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,000** person/**$12,000** family for network providers. No out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit PEHP Value Clinics: Starting at $10 co-pay	40% of Allowed Amount (AA) after deductible	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.
	Specialist visit	$40 co-pay/visit	40% of AA after deductible	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the Allowed Amount (AA) is under $350, 20% of AA after deductible if AA is over $350	40% of AA after deductible	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	No charge if the AA is under $350, 20% of AA after deductible if AA is over $350	40% of AA after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail, $25 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail, $50 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	$150 co-pay after deductible/ visit	$150 co-pay after deductible/visit	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$50 co-pay	40% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	$30/$40 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	40% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$40 co-pay/visit	40% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after deductible	40% of AA after deductible	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	---None---
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge for skilled nursing visit	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	*No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	*Sleep disorder supplies are limited to $325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires pre-authorization.
	Hospice service	No charge	40% of AA after deductible	---None---
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: $40 co-pay per visit.	40% of AA after deductible	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for network providers.
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Developmental delay — screening
- Foot care — routine
- Glasses
- Hearing aids
- Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Coverage provided outside the U.S.
- Dental care (Adults or children)
- Long-term care
- Routine eye care (Adults and children, exams only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711).

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next page.––––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,320
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,320**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pehp.org or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.pehp.org or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** single/**$5,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care received from network providers is not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,000** single/**$10,000** family for network providers. No out-of-pocket limit for out-of-network providers. Any one individual may not apply more than $8,150 toward the family out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% of Allowed Amount (AA) after deductible PEHP Value Clinics: 20% of AA after deductible	40% of Allowed Amount (AA) after deductible	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.
	Specialist visit	20% of AA after deductible	40% of AA after deductible	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	*Limited to the Preventive Plus list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% of AA after deductible	40% of AA after deductible	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	20% of AA after deductible	40% of AA after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay after deductible/ retail	The preferred co-pay after deductible plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost after deductible/retail, $25 minimum/No maximum	The preferred co-pay after deductible plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost after deductible/retail, $50 minimum/No maximum	The preferred co-pay after deductible plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

[* For more information about limitations and exceptions, see the plan or policy document at www.pehp.org.]

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	20% of AA after deductible	20% of AA after deductible	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	20% of AA after deductible	40% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	20% of AA after deductible	40% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after deductible	40% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after deductible	40% of AA after deductible	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	---None---
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible	40% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	20% of AA after deductible	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	*No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	*Sleep disorder supplies are limited to $325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires pre-authorization.
	Hospice service	20% of AA after deductible	40% of AA after deductible	———None———
If your child needs dental or eye care	Children's eye exam	No charge	40% of AA after deductible	*One routine exam per plan year.
	Children's glasses	Not covered	Not covered	———None———
	Children's dental check-up	Not covered	Not covered	———None———

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Developmental delay — screening
- Foot care — routine
- Glasses
- Hearing aids
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- Mental health and substance abuse care from an out-of-network provider
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- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next page.––––––––––––––––––––––

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This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $2,500
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,020
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,520**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2,500
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Primary care physician visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2,500
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

560 East 200 South » Salt Lake City, UT » 84102-2004 » 801-366-7555 or 800-765-7347 » www.pehp.org

Important Notices About Your Benefits

Several important notices about your PEHP benefits are included with this letter. To learn more, see your benefits summary and master policy. Find them at your Benefits Information Library at PEHP for Members at www.pehp.org . If you haven't created an online personal account, you'll need your PEHP ID and Social Security number. Find your PEHP ID number on your benefits card or your claims. Or call PEHP at 801-366-7555.

Notice of COBRA Rights

PEHP is providing you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to temporarily continue health Coverage if you are an Employee of an Employer with 20 or more Employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose PEHP Coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions please call the PEHP Office at 801-366-7555 or refer to the Benefits Summary and/or the PEHP Master Policy at www.PEHP.org.

There may be other Coverage available through the Healthcare Marketplace Exchange. Please see the Coverage Alternatives information at the end of this section.

Qualified Beneficiary
A Qualified Beneficiary is an individual who is covered under the Employer group health plan the day before a COBRA Qualifying Event.

Who is Covered

» Employees
If you have group health Coverage with PEHP, you have a right to continue this Coverage if you lose Coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

» Spouse of Employees
If you are the spouse of an Employee covered by PEHP, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose COBRA Coverage for yourself if you lose group health Coverage under PEHP for any of the following Qualifying Events:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

» Dependent Children
A Dependent child of an Employee who is covered by PEHP on the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to COBRA Coverage if group health Coverage under PEHP is lost for any of the following Qualifying Events:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under PEHP; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired.

A child who meets the definition of Dependent, who is born to or placed for adoption with the covered Employee during a period of COBRA Coverage is also a Qualified Beneficiary.

Secondary Qualifying Event
A Secondary Qualifying Event means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA Coverage under certain circumstances, from 18 months to 36 months of Coverage from the date of the original Qualifying Event.

Separate Election
If there is a choice among types of Coverage under the plan, each of you who are eligible for COBRA Coverage is entitled to make a separate election among the types of Coverage. Thus, a spouse or Dependent child is entitled to elect COBRA Coverage even if the covered Employee does not make that election. Similarly, a spouse or Dependent child may elect a different Coverage from the Coverage that the Employee elects.

Your Duties Under The Law
It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health plan in order to be eligible for COBRA Coverage. PEHP can be notified at 560 East 200 South, Salt Lake City, UT, 84102. PEHP Customer Service: 801-366-7555; toll free 800-765-7347. Appropriate documentation must be provided, such as: divorce decree, marriage certificate, etc.

Keep PEHP informed of address changes to protect you and your family's rights. It is important for you to notify PEHP at the above address if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

In addition, the covered Employee or a family Member must inform PEHP of a determination by the Social Security Administration that the covered Employee or covered family Member was disabled during the 60-day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month COBRA Coverage period. (See "Special rules for disability," below.) If, during continued Coverage, the Social Security Administration determines that the Employee or family Member is no longer disabled, the individual must inform PEHP of this redetermination within 30 days of the date it is made.

Employers' Duties Under The Law
Your Employer has the responsibility to notify PEHP of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility. Notice must be given to PEHP within 60 days of the occurrence of the above-listed events. When PEHP is notified that one of these events has happened, PEHP in turn will notify you and your Dependents that you have the right to choose COBRA Coverage. Under the law, you and your Dependents have up to 60 days from the date you would lose Coverage because of one of the events to inform PEHP that you want COBRA Coverage or 60 days from the date of your Election Notice.

Election of COBRA Coverage
Members have 60 days from either termination of Coverage or date of receipt of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again. If you choose COBRA Coverage, your Employer is required to give you Coverage that, as of the time Coverage is being provided, is identical to the Coverage provided under the plan to similarly situated Employees and their family Members. If you do not choose COBRA Coverage within the time period described above, your group health insurance Coverage will end.

Premium Payments
Payments must be made retroactively to the date of the qualifying event or loss of Coverage and paid within 45 days of the date of election. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of COBRA Coverage.

The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA Coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded.

How Long Will Coverage Last?
The law requires that you be afforded the opportunity to maintain COBRA Coverage for a maximum of 36 months, unless you lose group health Coverage because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months**.** Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the COBRA Coverage is in effect. Such events may extend an 18-month COBRA period to a maximum of 36 months, but in no event will COBRA Coverage extend beyond 36 months from the date of the event that originally made the Employee or a qualified beneficiary eligible to elect COBRA Coverage. You should notify PEHP if a second Qualifying Event occurs during your 18-month COBRA Coverage period.

Special Rules For Disability
If the Employee or covered family Member is disabled at any time during the first 60 days of COBRA Coverage, the COBRA Coverage period may be extended to 29 months for all family Members, even those who are not disabled.

The criteria that must be met for a disability extension is:
1. Employee or family Member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA Coverage.
3. Employee or family Member must notify PEHP of the disability no later than 60 days from the later of:
    a. the date of the Social Security Administration disability determination;
    b. the date of the Qualifying Event;
    c. the loss of Coverage date; or
    d. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.
4. Employee or family Member must notify Employer within the original 18 month COBRA period.
5. If an Employee or family Member is disabled and another qualifying event occurs within the 29-month COBRA period (other than bankruptcy of your Employer), then the COBRA Coverage period may continue up to a maximum of 36 months after the termination of employment or reduction in hours.

Special Rules For Retirees
In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, Coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.

COBRA Coverage May Be Terminated
The law provides that your COBRA Coverage may be terminated prior to the expiration of the 18-, 29-, or 36-month period for *any* of the following reasons:
1. Your Employer no longer provides group health Coverage to any of its Employees.
2. The premium for COBRA Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by PEHP that the Employee or family Member has committed any

of the following: fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA Coverage. However, under the law, you may have to pay all or part of the premium for your COBRA Coverage plus two percent.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

Questions
If you have any questions about continuing Coverage, please contact PEHP at 560 East 200 South, Salt Lake City, UT, 84102. Customer Service: 801-366-7555; toll free 800-765-7347.

Coverage Alternatives
There may be other Coverage options for you and your family. You are now able to buy Coverage through the Health Insurance Marketplace, which may cost less than COBRA. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Through the Marketplace you will also learn if you qualify for free or low-cost Coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You have 60 days from the time you lose your job-based Coverage to enroll in the Marketplace. After 60 days your special enrollment period will end and you may not be able to enroll, you should take action right away. In addition, during an "open enrollment" period, anyone can enroll in Marketplace Coverage.

If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through a "special enrollment period." If you terminate your COBRA early without a qualifying event, you will have to wait to enroll in Marketplace Coverage until the next open enrollment period, and could end up without any health Coverage in the interim.

If your COBRA ends you will be eligible to enroll in Marketplace Coverage through a special enrollment period event, if the Marketplace open enrollment has ended. If you sign up for Marketplace Coverage instead of COBRA, you cannot switch to COBRA under any circumstances.

You can access information regarding the Marketplace at HealthCare.gov or call 800-318-2596.

Notice of Women's Health and Cancer Rights Act

In accordance with The Women's Health and Cancer Rights Act of 1998, PEHP covers mastectomy in the treatment of cancer and Reconstructive Surgery after a mastectomy. If you are receiving benefits in connection with a mastectomy, Coverage will be provided according to PEHP's Medical Case Management criteria and in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction on the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical Complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Copayment Limitations consistent with those established for other benefits.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered.

All benefits are payable according to the schedule of benefits, based on this plan. Regular Preauthorization requirements apply.

Notice of Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance Coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g. physician, nurse midwife or physicians assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Notice of Privacy Practices for Protected Health Information

effective January 7, 2020

Public Employees Health Program (PEHP) our business associates and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we have adopted the following privacy principles and information practices. PEHP is required by law to maintain the privacy of your protected health information, and to provide you with this notice which describes PEHP's legal duties and privacy practices. Our practices apply to current and former members.

It is the policy of PEHP to treat all member information with the utmost discretion and confidentiality, and to prohibit improper release in accordance with the confidentiality requirements of state and federal laws and regulations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Types of Personal Information PEHP collects

PEHP collects a variety of personal information to administer a member's health, coverage. Some of the information members provide on enrollment forms, surveys, and correspondence includes: address, Social Security number, and dependent information. PEHP also receives personal information (such as eligibility and claims information) through transactions with our affiliates, members, employers, other insurers, and health care providers. This information is retained after a member's coverage ends. PEHP limits the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

Disclosure of your protected health information within PEHP is on a need-to-know basis. All employees are required to sign a confidentiality agreement as a condition of employment, whereby they agree not to request, use, or disclose the protected health information of PEHP members unless necessary to perform their job.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy,
- Better understand who, what, when, where, and why others may access your health information,
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that

compiled it, the information belongs to you. You have the rights as outlined in Title 45 of the Code of Federal Regulations, Parts 160 & 164:

- Request a restriction on certain uses and disclosures of your information, though PEHP is not required to agree with your requested restriction.
- Obtain a paper copy of the notice of information practices upon request (although we have posted a copy on our web site, you have a right to a hard copy upon request.)
- Inspect and obtain a copy of your health record.
- Amend your health records.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.

PEHP must provide the accounting within 60 days of receipt of your written request.
The accounting must include:

- Date of each disclosure
- Name and address of the organization or person who received the protected health information
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

Examples of Uses and Disclosures of Protected Health Information

PEHP will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

Though PEHP does not provide direct treatment to individuals, we do use the health information described above for utilization and medical review purposes. These review procedures facilitate the payment and/or denial of payment of health care services you may have received. All payments or denial decisions are made in accordance with the individual plan provisions and limitations as described in the applicable PEHP Master Policies.

PEHP will use your health information for payment.
For example: A bill for health care services you received may be sent to you or PEHP. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

PEHP will use your health information for health operations.
For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. *Example: Your employer contracts with PEHP to provide a health plan, and PEHP provides your employer with certain statistics to explain the rates we charge.* For specific health information PEHP will only provide information after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

There are certain uses and disclosures of your health information which are required or permitted by Federal Regulations and do not require your consent or authorization. Examples include:

Public Health.
As required by law, PEHP may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Business Associates.
There are some services provided in our organization through contacts with business associates. When such services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Food and Drug Administration (FDA).
PEHP may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation.
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Correctional Institution.
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement.
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Our Responsibilities Under the Federal Privacy Standard

PEHP is required to:

- Maintain the privacy of your health information, as required by law, and to provide individuals

with notice of our legal duties and privacy practices with respect to protected health information
- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality
- Implement a policy to discipline those who violate PEHP's privacy, confidentiality policies.
- Mitigate (lessen the harm of) any breach of privacy, confidentiality.
- To notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should we change our Notice of Privacy Practices you will be notified.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law. PEHP is prohibited from using or disclosing the genetic information of an individual for underwriting purposes.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. Other uses and disclosures not described in this notice of privacy practices require your written authorization.

Inspecting Your Health Information

If you wish to inspect or obtain copies of your protected health information, please send your written request to PEHP, Customer Service, 560 East 200 South, Salt Lake City, UT 84102-2099 We will arrange a convenient time for you to visit our office for inspection. We will provide copies to you for a nominal fee. If your request for inspection or copying of your protected health information is denied, we will provide you with the specific reasons and an opportunity to appeal our decision.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the PEHP Customer Service Department at (801) 366-7555 or (800) 955-7347

If you believe your privacy rights have been violated, you can file a written complaint with our Chief Privacy Officer at:

ATTN: PEHP Chief Privacy Officer
560 East 200 South
Salt Lake City, UT 84102-2099.

Alternately, you may file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.