2018-2019

Open Enrollment

State of Utah COBRA

Look inside for an overview of your benefits and what's new for the 2018-19 plan year.

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

PEHP Health & Benefits

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

April 2018

Dear PEHP Member:

PEHP is currently conducting annual enrollment. During this time you may make changes to your existing health coverage. This annual enrollment period will be the only opportunity to make voluntary changes to your coverage until the next open enrollment period.

Please note:

» **If you are NOT making changes to your existing plans, you don't need to complete an enrollment form.**

» Plan and benefit changes are effective July 1, 2018.

» To change plans, complete the enclosed enrollment change form, listing all covered dependents. Return it to PEHP by Friday, June 1, 2018.

» The new monthly rates are enclosed.

Your Benefits Summary, Summary of Benefits and Coverage (SBC), Uniform Glossary of Terms, Letter of Important Benefit Notices, and claims information are available through your PEHP for Members account at www.pehp.org. The examples shown in the SBC are created and defined by the Federal Government. They are not reflective of your group's specific benefit design.

If you have questions, contact PEHP at 801-366-7555 or 1-800-765-7347.

Sincerely,

PEHP Enrollment Department

04/25/18

Contents

2018-19 COBRA/Retiree Benefits Summary

See more details about medical and dental benefits available to you, including complete benefit grids, in the COBRA/Retiree Benefits Summary.
Access it in your Benefits Information Library at PEHP for Members. Or send an email to publications@pehp.org to request a printed copy.

Enrollment Timeline

May 1

» Your annual open enrollment period begins. It's the time of year you may switch from one medical, dental, or vision plan to another. Take this time to review your choices and learn more about the PEHP benefits available to you. Enroll at www.pehp.org.

June 1

» Deadline to enroll or make changes in medical, dental, or vision.

July 1

» New plan year begins. Deductibles and out-of-pocket maximums reset.

June 30, 2019

» 2018-19 plan year ends.

Highlights: 2018-19 Plan Year

Traditional Plan Copays

Copays remain the same, but some services are at different copay levels to better reflect comparative costs.

Use PEHP Cost Tools

You can now anticipate where your doctor is likely to send your lab and how much it may cost. You can also get dollar ratings for hospitals and other facilities. Compare costs in the Provider Lookup when you log in to PEHP for Members.

Send Secure Messages to PEHP

Have a question or can't find what you're looking for online? Log in to PEHP for Members and send us your questions via the Message Center. From the homepage, find "Messages" at the top-right.

Health Benefit Advisors

Need help deciding which plan to choose, whether to be covered by more than one plan, or different cost options for a service? Call a PEHP Health Benefit Advisor at 801-366-7555.

E-Care

Consult a doctor remotely with Intermountain Connect Care. Available on all PEHP networks. Visit www.intermountainconnectcare.org to get started.

Assisted Reproductive Technology

Beginning July 1, 2018, Traditional and STAR Plan members have the option of using a one-time $4,000 benefit for invitro fertilization. Preauthorization is required. For more information, call 801-366-7755 or 800-753-7754.

Looking for Lower Drug Costs?

Search for coverage and pricing for any medication available through your drug benefit plan. Log in to PEHP for Members, go to MyBenefits and click on Express Scripts Personal Account. You'll see medication prices from different pharmacies. To get the best deal, make sure you use the PEHP Preferred Drug List. You can call us for help, 801-366-7551 or 888-366-7551.

Plan Comparison Chart

MEDICAL PLAN	The STAR Plan (HSA-qualified)	Traditional (non-HSA)	Utah Basic Plus (HSA-qualified)
Medical Deductible	**$1,500** single plan **$3,000** double or family plan	**$350** per individual **$700** per family plan	**$3,000** single plan **$6,000** double or family plan
Out-of-Pocket Maximum	**Medical and Pharmacy:** **$2,500** single plan **$5,000** double plan **$7,500** family plan	**Medical and Pharmacy:** **$3,000** per individual **$6,000** per double plan **$9,000** per family plan *Deductible does not apply to out-of-pocket maximum*	**Medical and Pharmacy:** **$6,050** single plan **$12,100** double plan **$12,100** family plan
Benefits	Pays covered benefits generally at **80%** (using in-network providers, after deductible).	Pays covered benefits generally at **80%** (using in-network providers, after deductible).	Covers fewer services, generally at **70%** (using in-network providers, after deductible).
Eligibility	No special eligibility requirements for the plan. However, you must meet certain requirements to open an HSA and to contribute or receive contributions to it. Otherwise, your employer contribution will go into an HRA.	No special eligibility requirements. If you enroll in Traditional this year, you cannot enroll in Utah Basic Plus next open enrollment.	No special eligibility requirements for the plan. However, you must meet certain requirements to open an HSA and to contribute or receive contributions to it. Otherwise, your employer contribution will go into an HRA. **If you enroll in Utah Basic Plus this year, you can't switch to the Traditional Plan next open enrollment.**

Figures above based on Advantage & Summit Networks.

For more details, see the State of Utah COBRA/ER 2018-2019 Benefits Summary.

Find it at www.pehp.org/openenrollment or email publications@pehp.org

Summit

Steward*, **MountainStar**, and **University of Utah Health Care** providers and facilities. You can also see Advantage providers on the Summit network, but your benefits will pay less.

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

Carbon County
- Castleview Hospital

Davis County
- Lakeview Hospital
- Davis 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
- Huntsman Cancer Hospital
- Jordan Valley Hospital

Salt Lake County (cont.)
- Jordan Valley Hospital - West
- Lone Peak Hospital
- Primary Children's Medical Center
- Riverton Children's Unit
- St. Marks Hospital
- Salt Lake Regional Medical Center
- 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 Valley Medical Center

Utah County
- Mountain View Hospital
- Timpanogos Regional Hospital
- Mountain Point Medical Center

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- Ogden Regional Medical Center

No-Pay Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit. See List of No-Pay Providers at pehp.org

Advantage

Intermountain Healthcare (IHC) providers and facilities. You can also see Summit providers on the Advantage network, but your benefits will pay less.

Participating Hospitals

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital

Cache County
- Logan Regional Hospital

Carbon County
- Castleview Hospital

Davis County
- Davis 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
- Alta View Hospital
- Intermountain Medical Center

Salt Lake County (cont.)
- The Orthopedic Specialty Hospital (TOSH)
- LDS Hospital
- Primary Children's Medical Center
- Riverton Hospital

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 Valley Medical Center

Utah County
- American Fork Hospital
- Orem Community Hospital
- Utah Valley Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- McKay-Dee Hospital

Preferred

Consists of all providers and facilities in both the Summit and Advantage networks.

*Formerly IASIS

2018-2019 Monthly COBRA Rates			
Medical	**Single**	**Double**	**Family**
Advantage/Summit STAR	$452.45	$937.05	$1,296.18
Preferred STAR	$594.59	$1,231.49	$1,704.13
Advantage/Summit Traditional	$577.72	$1,191.18	$1,590.21
Preferred Traditional	$760.32	$1,567.77	$2,092.88
Advantage/Summit UT Basic Plus	$364.42	$761.00	$1,120.13
Preferred UT Basic Plus	$477.59	$997.51	$1,470.16
Dental	**Single**	**Double**	**Family**
Preferred Choice Dental	$29.19	$54.20	$98.66
Traditional Dental	$31.55	$58.56	$106.67
Expressions Dental	$48.88	$88.76	$159.86
Vision	**Single**	**Double**	**Family**
EyeMed Full	$7.49	$12.28	$17.05
EyeMed Eyewear Only	$6.46	$10.30	$14.14
OptiCare Full	$8.44	$13.47	$20.00
OptiCare Eyewear Only	$6.47	$9.85	$13.88

If you have any questions, please call customer service at (801) 366-7555
or toll free at (800)765-7347.

Dental Comparison

DENTAL PLAN	PEHP Preferred Choice	PEHP Traditional	Regence Expressions
Summary *This brief comparison is for illustrative purposes only.* *See your Benefits Summary for details.*	This PEHP plan shares the same dental network as Traditional. It has a small deductible that doesn't apply to preventive services. Pays 80% of in-network rate for X-rays and cleanings.	This PEHP plan shares the same dental network as Preferred Choice. It has no deductible. Pays 100% of in-network rate for X-rays and cleanings.	This plan is administered by Regence of Utah. It does not have a deductible and pays 100% of in-network rate for X-rays and cleanings. Has a national network of providers.
Deductible *Doesn't apply to preventive services*	$25 per member up to $75 per family	Not Applicable	Not Applicable
Maximum Benefit	Maximum yearly benefit of $1,500 per member	Maximum yearly benefit of $1,500 per member	Maximum yearly benefit of $1,500 per member
Networks	Share the same provider network. **Important Note:** If you use an out-of-network dentist, your benefit will be 20% less and you may be balance billed.		Has a national provider network. If you see an out-of-network provider, the plans will pay the in-network rate, and you may be balance billed.

PEHP Value Clinics » 10% discount on what you would normally pay an in-network provider.

Waiting Period » There is a waiting period of six months from the effective date of coverage for orthodontic, implant, and prosthodontic benefits, unless you've had previous, continuous coverage. Learn more in the Dental Master Policy.

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP. Learn more in the Dental Master Policy.

PEHP Health & Benefits
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Fax: 801-366-7599
www.pehp.org

Medical Dental, Vision
Enrollment and Change Form
State of Utah COBRA

Important Note: Changes made on this form will affect your medical, dental, and vision coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans. **Please print clearly.**

☐ Termination ☐ Annual Enrollment Change Request (Please Specify Type):_____

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS ☐ SINGLE ☐ MARRIED	GENDER ☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE		

Group Medical (check one)

Coverage type (Check one)
- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents
- ☐ No medical coverage at this time

Choose your network
- ☐ Summit Network
- ☐ Advantage Network
- ☐ Preferred Network

Choose your medical plan
- ☐ The STAR Plan
- ☐ Traditional
- ☐ Utah Basic Plus

Utah Basic Plus is only available to new hires and members previously enrolled in The STAR Plan.

GROUP DENTAL (Check one)
- ☐ Preferred Choice Dental
- ☐ Traditional Dental
- ☐ Regence Expressions
- ☐ No dental coverage at this time

Coverage type (Check one)
- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

VISION (Check one)
- ☐ Eyemed – Full
- ☐ Eyemed – Eyewear Only
- ☐ Opticare – Full
- ☐ Opticare – Eyewear Only
- ☐ No vision coverage at this time

Coverage type (Check one)
- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus 2+ dependents

ADDITIONS List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. PEHP benefits will not be processed until required documentation is received.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
CODE KEY: **S »** Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Explanations)	**S**			☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? ☐ **Yes** ☐ **No** **If yes, complete Multiple Group Coverage Section on back**

REMOVALS Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE*	COVERAGE TERMINATED
S » Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Explanations)						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision

*Applicable Date is the date of marriage, divorce, birthday, etc.

Signature required on other side.

(HR use only) **ST-C** 04-24-17

Effective Date:_____Termination Date:_____HR Approval:_____

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Employee Name: _____ Social Security Number: _____

Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	Effective Date (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDANTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Explanations

Employee Agreement and Signature

Before signing, make sure that all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify PEHP within **60 days of any changes** effecting coverage and/or dependent eligibility (e.g., birth marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP for any claims paid in error; (5) agree to the terms and conditions in the PEHP Master Policy.

Employee Signature	Date

Please make a copy for your records.

IMPORTANT NOTICE ABOUT YOUR EMPLOYER'S 2018 PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D PLANS

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering enrolling, you should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current prescription drug coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you enroll in a Medicare Prescription Drug Plan or enroll in a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEHP has determined the 2018 prescription drug coverage offered by your employer's plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing prescription drug coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan.

When Can You Enroll in a Medicare Drug Plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year thereafter during Medicare open enrollment, from October 15 to December 7. Coverage begins on January first for those enrolling during open enrollment. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month special enrollment period (SEP) to enroll in a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Enroll in a Medicare Drug Plan?

If you decide to enroll in a Medicare drug plan, your current prescription drug coverage through your employer may be affected in accordance with the Center for Medicare and Medicaid Services (CMS). **The 2018 prescription drug plans offered by your employer provided by PEHP are creditable**.

If you do decide to enroll in a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will be able to get your employer coverage back IF you and your dependents are still eligible for employer-based coverage.

When Will You Pay A Higher Premium (Penalty) to Enroll in a Medicare Drug Plan?

You should also know if you drop or lose your current prescription drug coverage with your employer and don't enroll in a Medicare drug plan within 63 continuous days after your current prescription drug coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have prescription drug coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug.

For More Information About This Notice Or Your Current Prescription Drug Coverage.

Contact PEHP's Customer Service Department regarding your current prescription drug coverage at 800-765-7347 or 801-366-7575. For more information about this notice please contact your employer's benefit specialist.

NOTE: You'll get this notice each year. You will also get this notice before the next period you can enroll in a Medicare prescription drug plan, and if this prescription drug coverage through your employer changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

Visit www.medicare.gov or, call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800- 772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you enroll to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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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 and /or dental 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 Benefit Summary and/or the PEHP Master Policy at www.pehp.org.

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 or dental 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 continuation coverage for yourself if you lose group health coverage under PEHP for any of the following reasons:

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 covered by PEHP where and the Dependent is covered by PEHP the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to continuation coverage if group health coverage under PEHP is lost for any of the following reasons:

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;

6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired; or

7. As defined by your employer.

A child born to, or placed for adoption with, the covered employee during a period of continuation coverage is also a Qualified Beneficiary.

SECONDARY EVENT

A Secondary 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. The Secondary Event 36 months of coverage extends 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 is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or Dependent child is entitled to elect continuation of 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/dental plan in order to be eligible for COBRA continuation 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 continuation 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.

EMPLOYER'S DUTIES UNDER THE LAW

Your Employer has the responsibility to notify PEHP of the employee's death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to PEHP within 60 days of the happening of the event. 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 continuation coverage. Under the law, you and your dependents have at least 60 days from the date you would lose coverage because of one of the events described above to inform PEHP that you want continuation coverage or 60 days from the date of your Election Notice.

Important Benefit Notices Letter

ELECTION OF CONTINUATION 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 continuation 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 or family members, including the right during the employer's open enrollment period to choose among available coverage options. If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

PREMIUM PAYMENTS

Payments must be made back to the date of the qualifying event 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 coverage.

The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation 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 continuation 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 continuation coverage for 36 months, unless you lose group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation coverage period is 18 months**.** Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. Such events may extend an 18-month COBRA continuation period to 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 COBRA continuation 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 continuation coverage, the continuation 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:

» Employee or family member must be determined by the Social Security Administration to be disabled.

» Must be determined disabled during the first 60 days of COBRA coverage.

» Employee or family member must notify PEHP of the disability no later that 60 days from the later of:

» the date of the SSA disability determination; or

» the date of the Qualifying Event, or

» the loss of coverage date, or

» the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.

» Employee or family member must notify employer within the original 18 month continuation period.

» If an employee or family member is disabled and another qualifying event occurs within the 29-month continuation period (other than bankruptcy of your Employer), then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

SPECIAL RULE 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.

CONTINUATION COVERAGE MAY BE TERMINATED

The law provides that your continuation coverage may be cut short 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 continuation 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 continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage plus 2%.

The law also states that, at the end of the 18, 29, or 36 month COBRA continuation coverage period, you are allowed to enroll in an individual conversion health plan provided by PEHP.

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. More information regarding COBRA may be found in the PEHP Master Policy, and your Plan's Benefit Summary found at www.pehp.org.

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.

Notice of Women's Health and Cancer Rights Act

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), 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.

Medical services received more than 5 years after a surgery covered under this section will not be considered a complication of such surgery.

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 pre-authorization 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 Exemption from HIPAA

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local government employers that sponsor health plans to elect to exempt a plan from these requirements for part of the plan that is self-funded by the employer, rather than provided through an insurance policy. PEHP has elected to exempt your plan from the following requirement:

» Application of the requirements of the 2008 Wellstone Act and the 1996 Mental Health Parity Act;

» The exemption from this Federal requirement will be in effect for the 2018-19 plan year. The election may be renewed for subsequent plan years.

HIPAA also requires PEHP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under PEHP. There is no exemption from this requirement. The certificate provides evidence that you were covered under PEHP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a Pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Notice of Privacy Practices for Protected Health Information

effective August 31, 2013

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, life, and long term disability 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.
- That occurred before April 14, 2003.

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. PEHP will only do so 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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 7/1/18-6/30/19**

Group Name: State of Utah STAR Summit & Advantage **Coverage for:** Individual and Family plans | **Plan Type:** PPO

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?	$1,500 single/$3,000 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?	$2,500 single/$5,000 double/$7,500 family for network providers. No out-of-pocket limit for out-of-network providers. Any one individual may not apply more than $7,350 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 e-Care: $10 co-pay per visit after deductible PEHP Value Clinics: 20% of AA after deductible	40% of Allowed Amount (AA) after deductible	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	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	*Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. *Infertility services are payable at 50% of AA after deductible for eligible services. *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. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires 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, plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*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 medications 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. 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	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	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	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) requires pre-authorization after the initial evaluation, maximum limit 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	*Requires pre-authorization. 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. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization.
	Hospice service	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. 6 months in a 3-year period maximum.
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---

[* 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
- Dental care (Adults or children)
- Developmental delay — testing and treatment
- 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, residential treatment programs
- 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
- 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.
- 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** $1,500
- **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	$1,500
Copayments	$0
Coinsurance	$1,220
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,720**

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

- **The plan's overall deductible** $1,500
- **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	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,300**

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

- **The plan's overall deductible** $1,500
- **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	$1,500
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 7/1/18-6/30/19**
Group Name: State of Utah Traditional Summit, Advantage & Preferred **Coverage for:** Individual and Family plans | **Plan Type:** PPO

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?	**$350** person/**$700** family for network providers and out-of-network providers. Doesn't apply to network provider visits or preventive care received from network providers.	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?	**$3,000** person/**$6,000** double/**$9,000** 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	$25 co-pay/visit Intermountain or Univ. of Utah Medical Group: $35 co-pay/visit PEHP e-Care: $10 co-pay/visit PEHP Value Clinics: $10 co-pay	40% of Allowed Amount (AA) after deductible	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	$35 co-pay/visit Intermountain or Univ. of Utah Medical Group: $45 co-pay	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)	20% of Allowed Amount after deductible	40% of AA after deductible	*Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. *Infertility services are payable at 50% of AA after deductible for eligible services. *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/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. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires 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, minimum $150 co-pay per visit	20% of AA, minimum $150 co-pay per visit, plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*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	$45 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 medications 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	$25/$35 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	$35 co-pay/visit Intermountain or Univ. of Utah Medical Group: $45 co-pay	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. 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	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	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	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	Inpatient: 20% of AA after deductible. Outpatient: $35 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) requires pre-authorization after the initial evaluation, maximum limit 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	Inpatient: 20% of AA after deductible. Outpatient: $35 co-pay/visit	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. 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. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization.
	Hospice service	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. 6 months in a 3-year period maximum.
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: $35 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
- Dental care (Adults or children)
- Developmental delay — testing and treatment
- 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, residential treatment programs
- 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
- 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.
- 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** $350
- **Specialist copayment** $35
- **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	$350
Copayments	$0
Coinsurance	$1,450
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,800**

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

- **The plan's overall deductible** $350
- **Specialist copayment** $35
- **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	$350
Copayments	$0
Coinsurance	$1,030
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,380**

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

- **The plan's overall deductible** $350
- **Specialist copayment** $35
- **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	$350
Copayments	$0
Coinsurance	$430
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

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?	**$3,000** single/**$6,000** 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?	**$6,050** single/**$12,100** double or family for network providers. No out-of-pocket limit for out-of-network providers. Any one individual may not apply more than $7,350 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	30% of Allowed Amount (AA) after deductible PEHP e-Care: $10 co-pay per visit after deductible PEHP Value Clinics: 30% of AA after deductible	50% of Allowed Amount (AA) after deductible	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay.
	Specialist visit	30% of AA after deductible	50% of AA after deductible	
	Preventive care/ screening/immunization	No charge	50% 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)	30% of AA after deductible	50% of AA after deductible	*Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	30% of AA after deductible	50% 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	30% of discounted cost after deductible/retail	Not covered	*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	30% of discounted cost after deductible/retail	Not covered	
	Non-preferred brand drug	Not covered	Not covered	
	Specialty drugs	30% of AA after deductible	Not covered	*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)	30% of AA after deductible	50% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery; breast reduction; blepharo-plasty; infertility surgery; sclerotherapy of varicose veins; micro-phlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	30% of AA after deductible	50% of AA after deductible	
If you need immediate medical attention	Emergency room care	30% of AA after deductible	30% of AA after deductible, plus any balance billing	---None---
	Emergency medical transportation	30% of AA after deductible	30% of AA after deductible, plus any balance billing	*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	30% of AA after deductible	50% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% of AA after deductible	50% of AA after deductible	*Take-home medications 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% of AA after deductible	50% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	30% of AA after deductible	50% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relax-ation therapy, conduct disorders, oppositional disorders, learning disabili-ties, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	30% of AA after deductible	50% of AA after deductible	
If you are pregnant	Office visits	30% of AA after deductible	50% of AA after deductible	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	30% of AA after deductible	50% of AA after deductible	
	Childbirth/delivery facility services	30% of AA after deductible	50% 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	30% of AA after deductible	50% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 30 visits per plan year.
	Rehabilitation services	30% of AA after deductible	50% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) / Speech Therapy (ST) is limited to 10 combined visits per plan year. Speech Therapy requires preauthorization. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation/skilled nursing is limited to 30 days per plan year and requires pre-authorization. Custodial care is not covered.
	Habilitation services	30% of AA after deductible	50% of AA after deductible	
	Skilled nursing care	30% of AA after deductible	50% of AA after deductible	
	Durable medical equipment	30% of AA after deductible	50% of AA after deductible	*Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization.
	Hospice service	30% of AA after deductible	50% of AA after deductible	*Requires pre-authorization. 6 months in a 3-year period maximum.
If your child needs dental or eye care	Children's eye exam	No charge	50% of AA after deductible	*One time between ages 3-5.
	Children's glasses	30% of AA after deductible	30% of AA after deductible	Lenses only. One time per plan year. Age 3 through the end of the month in which the member turns 19 years of age. Can see provider of choice
	Children's dental check-up	30% of AA after deductible	50% of AA after deductible	Routine cleaning, exams, x-rays and fluoride. Two times per plan year. Age 3 through the end of the month in which the member turns 19 years of age. Sealants once every five years. See Master Policy for details.

[* 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
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Dental care (Adults)
- Developmental delay — testing and treatment
- Foot care — routine
- Glasses
- Hearing aids
- Infertility services
- 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, residential treatment programs
- 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 Utah Basic Plus formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication
- Temporomandibular Joint Dysfunction
- Sleep studies and equipment
- 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.
- 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	$3,000
Specialist copayment	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,000
Copayments	$0
Coinsurance	$1,380
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,380**

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

The plan's overall deductible	$3,000
Specialist copayment	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,000
Copayments	$0
Coinsurance	$750
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,750**

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

The plan's overall deductible	$3,000
Specialist copayment	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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.

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

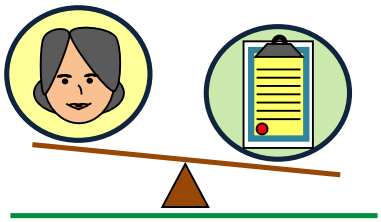
When a provider bills you for the balance remaining on the bill that is not covered by your plan. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $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

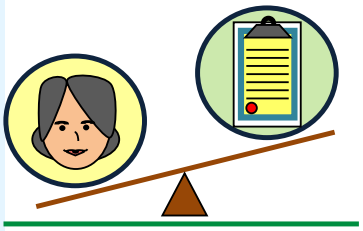
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your 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.

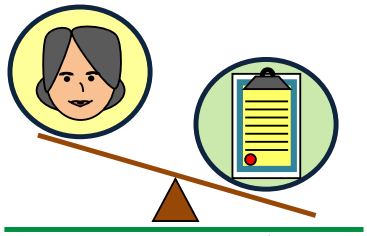
Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

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

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.



(See page 6 for a detailed example.)

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.

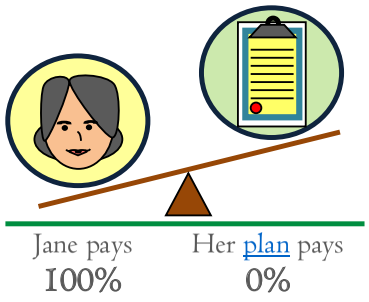
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

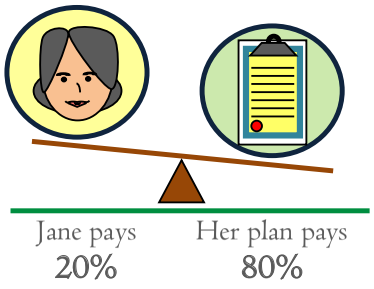
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

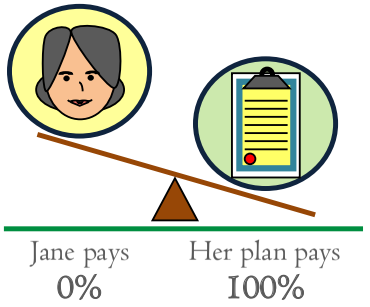
December 31st
End of Coverage Period



more costs



more costs



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

Instructions for Compliance with Delivery of Summary of Benefits and Coverage (SBC)

The new Summary of Benefits and Coverage (SBC) and the Uniform Glossary must be distributed to all employees eligible for health benefits (whether or not they are currently enrolled in your health plan) at the following times:

1) On or before annual open enrollment begins;
2) 60 days prior to any material change in the benefits of the plan during the plan year;
3) Upon a Special Enrollment Event mid-year; and
4) Within 7 business days upon request by any employee.

Because this document must be distributed to all employees *eligible for coverage* whether they are actually enrolled in PEHP health coverage or not, PEHP must enlist the assistance of you, as the employer, to distribute this to all eligible employees at:

- The time of open enrollment;
- At any special enrollment event (marriage, divorce, birth, etc); and
- Within 7 business days of an employee's request.

PEHP has provided an electronic version of your group's specific SBC(s). We've also included a letter than contains important benefit notices that employees must receive each year. Following the instructions listed below will allow for compliance with the federal requirements. You must be able to show that each employee "actually received" the SBC or you could face federal penalties for noncompliance.

Instructions for employer distribution of Summary of Benefits and Coverage (SBC) and the Uniform Glossary:

1) Review PDF attachment(s) to insure that you are able to read/distribute/print this material. Because this document is time sensitive, if you cannot read the material, please contact your PEHP Client Services Representative immediately.
2) Determine/create a list of which employees receive email as a normal part of their work responsibilities.
3) Email the PDF to employees who are able to receive email as normal part of their work responsibilities on or before your open enrollment begins.
4) Print copies of the applicable SBC(s) and Uniform Glossary and hand deliver or mail to those employees who do not receive email as a normal part of their work responsibilities on or before open enrollment begins.
5) (Optional) If you have an intranet site, provide a continuous link on employer intranet site to the SBC.