2013-2014

Benefits Summary

State of Utah

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

PEHP Serving the Employees Who Serve Utah

Start looking at healthcare in a completely different way.

You don't just walk into the dealership and sign on the dotted line without looking at the price tag on the car you're buying. You don't let the contractor tear up your kitchen before you know how much the remodel's going to cost. And you don't book the first cruise you come across online without comparing prices at other sites. But when it comes to healthcare, these are exactly the kinds of things we're used to doing.

Now, for PEHP members, **that's all about to change.**

COST & QUALITY TOOLS

Cost Calculator
Compare costs among medical providers. Estimate out-of-pocket costs based on your specific plan and network.

Quality & Code Lookup
Get costs for things the cost calculator doesn't cover or look up by code. See providers' reviews and performance benchmarks.

Find a Medication
Find the best value for prescription drugs. See coverage and pricing for any covered medicine based on your benefits.

Cost-Saving Tips
Use tools and information here to get the best healthcare value and avoid unnecessary medical bills.

One Place, One Password at myPEHP

These pioneering tools are waiting for you at myPEHP. Log in at www.pehp.org. Or create an account. You'll need your PEHP ID and your Social Security number. Find your PEHP ID number on your benefits card or your claims, or call PEHP at 801-366-7555.

How Much Can You Save? You might be surprised to learn how much out-of-pocket costs vary from one provider to the next.

PEHP

State of Utah
2013-2014

State of Utah Benefits Summary

STATE OF UTAH
Benefits Summary

Effective July 2013
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This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP subscribers who are employed by the State of Utah and their eligible dependents. Members of any other PEHP plan should refer to the applicable publications for their coverage.

It is important to familiarize yourself with the information provided in this Benefits Summary and the PEHP Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP. You may also view it at www.pehp.org.

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP. The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at www.pehp.org. All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

The information in this Benefits Summary is distributed on an "as is" basis, without warranty. While every precaution has been taken in the preparation of this Benefits Summary, PEHP shall not incur any liability due to loss, or damage caused or alleged to be caused, directly or indirectly by the information contained in this Benefits Summary.

The information in this Benefits Summary is intended as a service to members of PEHP. While this information may be copied and used for your personal benefit, it is not to be used for commercial gain.

The employers participating with PEHP are not agents of PEHP and do not have the authority to represent or bind PEHP.

7/18/2013

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Welcome to PEHP

We want to make accessing and understanding your healthcare benefits simple. This Benefits Summary contains important information on how best to use PEHP's comprehensive benefits.

Please contact the following PEHP departments or affiliates if you have questions.

ON THE WEB

»myPEHP . . . . . www.pehp.org

myPEHP is your online source for personal health and plan benefit information. Review your claims history, see a comprehensive list of your coverages, look up contracted providers, check your FLEX$ account balance, and more. Create a myPEHP account to enroll in PEHP benefits electronically.

CUSTOMER SERVICE

. 801-366-7555
. . . . . or 800-765-7347

Weekdays from 8 a.m. to 5 p.m.
Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

PRE-NOTIFICATION/PRE-AUTHORIZATION

»Inpatient hospital pre-notification 801-366-7755
. . . . . or 800-753-7754

MENTAL HEALTH/SUBSTANCE ABUSE PRE-AUTHORIZATION

»PEHP Customer Service. 801-366-7555
. . . . . or 800-765-7347

PRESCRIPTION DRUG BENEFITS

»PEHP Customer Service. 801-366-7555
. . . . . or 800-765-7347

»Express Scripts 800-903-4725
. . . . . .www.express-scripts.com

SPECIALTY PHARMACY

»Accredo 800-501-7260

GROUP TERM LIFE AND AD&D

»PEHP Life and AD&D 801-366-7495

PEHP FLEX$

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

HEALTH SAVINGS ACCOUNTS (HSA)

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

»HealthEquity 866-960-8058
. . . . . .www.healthequity.com/stateofutah

WELLNESS AND DISEASE MANAGEMENT

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

»PEHP Waist Aweigh 801-366-7300
. . . . . or 800-366-7300
. . . . . www.pehp.org

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

VALUE-ADDED BENEFITS PROGRAM

»PEHPplus . . . . . www.pehp.org/plus

»Blomquist Hale 800-926-9619
. . . . . www.blomquisthale.com

ONLINE ENROLLMENT HELP LINE

. 801-366-7410
. . . . . or 800-753-7410

CLAIMS MAILING ADDRESS

PEHP
560 East 200 South
Salt Lake City, UT 84102-2004

Benefit Changes

All Medical Plans

- Effective 2013, new preventive services for women have been added to the federal healthcare reform list of services available at no cost to you. For a complete list of preventive services, see the Master Policy at myPEHP at www.pehp.org.
- Medco, PEHP's pharmacy benefit manager, is now known as Express Scripts. Access your pharmacy benefits at myPEHP.
- You can now shop for healthcare value, compare prices among providers, and save money using PEHP's new Cost & Quality Tools, accessible at myPEHP.
- Would you save money on The STAR Plan? Visit myPEHP to get a personalized estimate based on your current benefits and utilization.
- Employee rates for the traditional plan have increased to: $19.79 biweekly for a single plan; $40.80 biweekly for a double plan; and $54.47 biweekly for a family plan. Rates for The STAR Plan and Utah Basic Plus remain the same.

Dental Plans

- No PEHP Dental increase. Regence Expressions increased to: $4.34/single, $15.66/double, $22.50/family.

Legislative Bills

HB 47 – This bill passed during the most recent legislative session. It means you can no longer continue on The STAR Plan after you leave state employment.

FLEX$

Because of federal healthcare reform, the medical maximum is now $2,500. Dependent day care remains $5,000. You can now use your FLEX$ Benefits Card as a debit card. Go to myPEHP to get your PIN (click "Check Your FLEX$ Balance" from the menu at left, then click "Card Status").

This is just a brief overview of changes. Please see the Master Policy for complete benefit information.

Employee Rates, Enrollment Dates

Biweekly Medical Contributions

	Employer (biweekly)	Biweekly Employer HSA Contribution*	Employee (biweekly)	Total biweekly cost of plan
The STAR Plan (Advantage Care & Summit Care)				
Single	$149.24	$28.85	0	$178.09
Double	$309.51	$57.70	0	$367.21
Family	$432.52	$57.70	0	$490.22
The STAR Plan (Preferred Care)				
Single	$149.24	$28.85	$49.01	$227.10
Double	$309.51	$57.70	$101.05	$468.26
Family	$432.52	$57.70	$134.91	$625.13
Traditional Plan (Advantage Care & Summit Care)				
Single	$178.09	N/A	$19.79	$197.88
Double	$367.21	N/A	$40.80	$408.01
Family	$490.22	N/A	$54.47	$544.69
Traditional Plan (Preferred Care)				
Single	$178.09	N/A	$82.35	$260.44
Double	$367.21	N/A	$169.79	$537.00
Family	$490.22	N/A	$226.66	$716.88
Utah Basic Plus (Advantage Care & Summit Care)				
Single	$111.74	$66.35	0	$178.09
Double	$234.52	$132.69	0	$367.21
Family	$357.53	$132.69	0	$490.22
Utah Basic Plus (Preferred Care)				
Single	$111.74	$66.35	$39.23	$217.32
Double	$234.52	$132.69	$80.88	$448.09
Family	$357.53	$132.69	$107.98	$598.20

* You'll receive your HSA contributions semi-annually, half in July 2013 and half in January 2014.

Biweekly Dental Contributions

	Employer	Employee	Total
Preferred Choice			
Single	$20.18	$2.24	$22.42
Double	$25.66	$2.85	$28.51
Family	$37.18	$4.13	$41.31
Traditional			
Single	$20.18	$4.07	$24.25
Double	$25.66	$5.17	$30.83
Family	$37.18	$7.49	$44.67
Regence Expressions			
Single	$20.18	$4.34	$24.52
Double	$25.66	$15.66	$41.32
Family	$37.18	$22.50	$59.68

Biweekly Vision Contributions

	Employee
EyeMed	
Single	$4.17
Double	$7.01
Family	$9.85

	Employee
Opticare	
Single	$4.15
Double	$6.99
Family	$8.99

Open Enrollment Dates

Medical, Dental, Vision..... April 11 - June 14

Group Life ..... Enroll any time

AD&D..... Enroll any time

FLEX$..... April 11 – June 14

ARE YOU MAKING CHANGES?

The annual open enrollment period is the only time during the year you can switch from one medical, dental, or vision plan to another.

Make changes or confirm your coverage online at www.pehp.org (through myPEHP).

PEHP Online Tools

Access Benefits and Claims at myPEHP

WWW.PEHP.ORG

Access important benefit tools and information by creating a myPEHP account at www.pehp.org.

- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.
- » Get important plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Access your FLEX$ account.
- » Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you'll get an email every time a new one is available at myPEHP.
- » Change your mailing address.

Find a Provider

WWW.PEHP.ORG

Looking for a provider, clinic, or facility that is contracted with your plan? Look no farther than www.pehp.org. Go online to search for providers by name, specialty, or location.

Access Your Pharmacy Account

WWW.EXPRESS-SCRIPTS.COM

Create an account with Express Scripts, PEHP's pharmacy benefit manager, and get customized information that will help you get your medications quickly and at the best price.

Go to www.express-scripts.com to create an account. All you need is your PEHP ID card and you're on your way.

You'll be able to:

- » Check prices.
- » Check an order status.
- » Locate a pharmacy.
- » Refill or renew a prescription.
- » Get mail-order instructions.
- » Print a temporary pharmacy card.
- » Find detailed information specific to your plan, such as drug coverage, copayments, and cost-saving alternatives.

PEHP Medical Networks

PEHP Advantage Care

The PEHP Advantage Care network of contracted providers consists of predominantly Intermountain Healthcare (IHC) providers and facilities. It includes 34 participating hospitals and more than 7,500 participating providers.

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
- Valley View Medical Center

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Medical Center
- 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 Medical Center

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 Regional Medical Center

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- McKay-Dee Hospital

PEHP Preferred Care

The PEHP Preferred Care network of contracted providers consists of providers and facilities in both the Advantage Care and Summit Care networks. It includes 46 participating hospitals and more than 12,000 participating providers.

PEHP Summit Care

The PEHP Summit Care network of contracted providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 38 participating hospitals and more than 7,500 participating providers.

PARTICIPATING HOSPITALS

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

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

Cache County
- Logan Regional 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
- Valley View Medical Center

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Medical Center
- Fillmore Community Hospital

Salt Lake County
- Huntsman Cancer Hospital
- Jordan Valley Hospital

Salt Lake County (cont.)
- Pioneer Valley 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 Medical Center

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

Wasatch County
- Heber Valley Medical Center

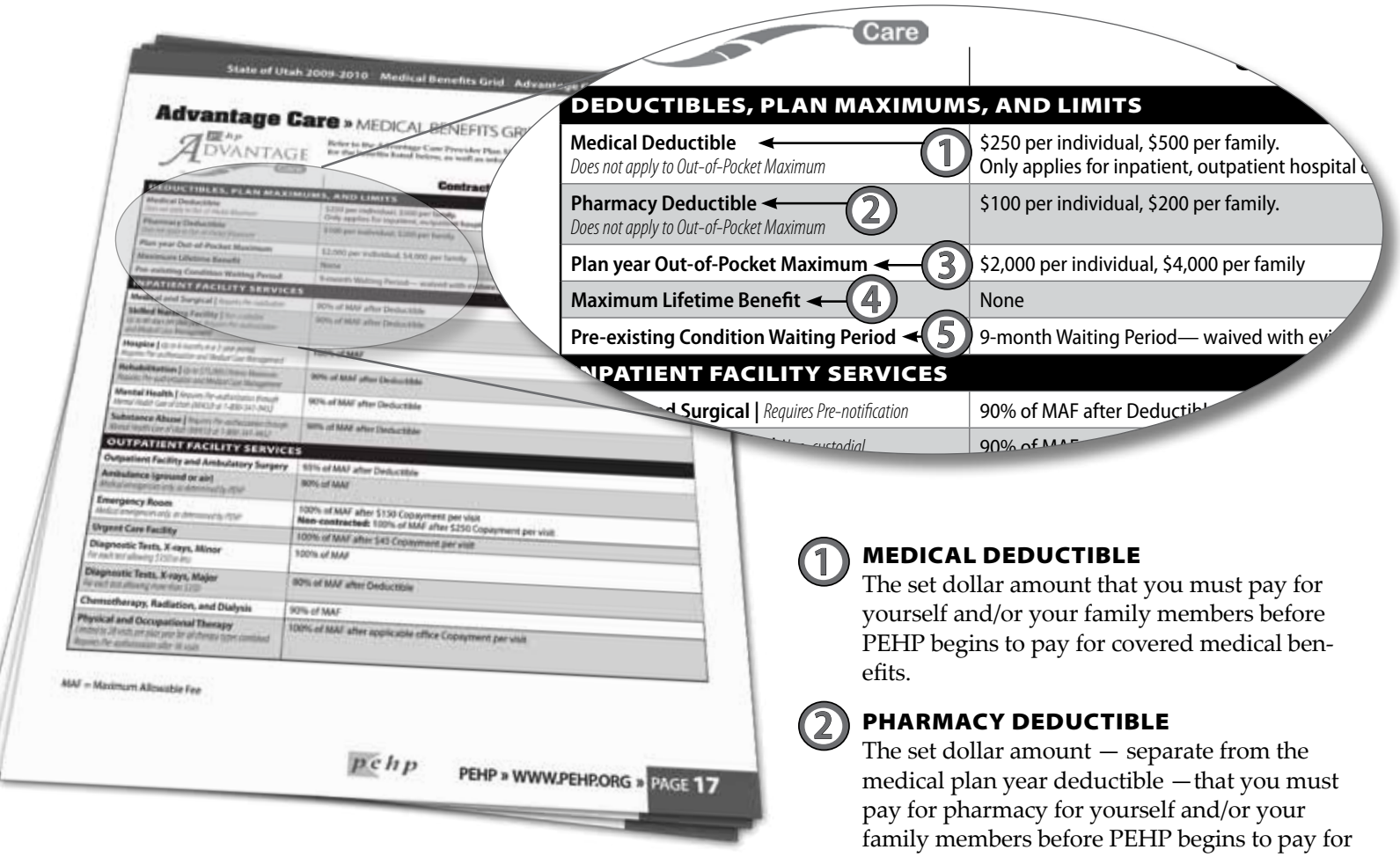
Washington County
- Dixie Regional Medical Center

Weber County
- Ogden Regional Medical Center

Find Participating Providers

Go to www.pehp.org to look up participating providers for each plan.

Understanding Your Benefits Grid



COPAYMENT
A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP Allowed Amount.

CONTRACTED
Contracted benefits apply when you receive covered services from contracted providers. You are responsible to pay the applicable copayment.

NON-CONTRACTED
If your plan allows the use of non-contracted providers, non-contracted benefits apply when you receive covered services. You are responsible to pay the applicable copayment, plus the difference between the billed amount and PEHP's Maximum Allowable Fee (see Page 9).

ALLOWED AMOUNT (AA)
A schedule of maximum allowable fees established by PEHP and accepted by contracted providers, along with any required member copayment as payment in full (see Page 9).

1 MEDICAL DEDUCTIBLE
The set dollar amount that you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits.

2 PHARMACY DEDUCTIBLE
The set dollar amount — separate from the medical plan year deductible —that you must pay for pharmacy for yourself and/or your family members before PEHP begins to pay for covered pharmacy benefits.

3 PLAN YEAR OUT-OF-POCKET MAXIMUM
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (includes deductibles on the STAR and Utah Basic Plus plans).

4 MAXIMUM LIFETIME BENEFIT
The total amount the plan pays for each covered family member in his or her lifetime.

5 PRE-EXISTING CONDITION WAITING PERIOD
A condition that is present six months before your plan enrollment date for which medical treatment, consultation, or diagnostic testing was received. This section tells you if you have a waiting period before coverage for a pre-existing condition begins.

Understanding Contracted Providers

This year, State of Utah plans pay limited benefits for non-contracted providers. It's important to understand the difference between contracted and non-contracted providers and how the Allowed Amount works to avoid unexpected charges.

Allowed Amount

Doctors and facilities contracted with your network — contracted providers — have agreed not to charge more than PEHP's Allowed Amount (AA) for specific services. Your benefits are often described as a percentage of the AA. With contracted providers, you pay a predictable amount of the bill: the remaining percentage of the AA. For example, if PEHP pays your benefit at 80% of AA, your portion of the bill generally won't exceed 20% of the AA.

Balance Billing

It's a different story with non-contracted providers. They may charge more than the AA unless they have an agreement with you not to. These doctors and facilities, who aren't a part of your network, have no pricing agreement with PEHP. The portion of the benefit PEHP pays is based on what we would pay a contracted provider. You'll be billed the full amount that the provider charges above the AA. This is called "balance billing."

Negotiate a Price

DON'T GET BALANCE BILLED

Although non-contracted providers are under no obligation to charge within the AA, consider negotiating the price before you receive the service to avoid being balance billed.

Understand that charges to you may be substantial if you see a non-contracted provider. Your plan generally pays a smaller percentage of the AA, and you'll also be billed for any amount charged above the AA.

The amount you pay for charges above the AA won't apply to your deductible or out-of-pocket maximum.

Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the comparison on Page 3 or go to www.pehp.org to see which network includes your doctors.

Ask questions before you get medical care. Make sure every person and every facility involved is contracted with your plan.

Although non-contracted providers are under no obligation to charge within the AA, consider negotiating the price before you receive the service to avoid being balance billed.

Go to www.pehp.org and click "Find a Provider" to find a doctor or facility contracted with your network.

Health Savings Accounts

About Health Savings Account (HSA)

An HSA is a tax-advantaged, interest-bearing account. Your money goes in tax-free, grows tax-free, and can be spent on qualified health expenses tax-free. An HSA can be a great way to save for health expenses in both the short and long term.

An HSA is similar to a flexible spending account; you contribute pre-tax dollars to pay for eligible health expenses.

An HSA has several advantages. You never have to forfeit what you don't spend. Your money carries over from year-to-year and even from employer-to-employer. All the while, an HSA can earn tax-free interest in a savings account.

The STAR Plan employer HSA contributions for 2013-14 will be $750 for a single plan and $1,500 for double and family plans. Contributions will be frontloaded semi-annually, half in July 2013 and half in January 2014.

Utah Basic Plus employer HSA contributions for 2012-13 will be $1,725 for a single plan and $3,450 for a double and family plan. Contributions will be front-loaded semi-annually, half in July 2013 and half in January 2014.

You can also contribute to an HSA much like you would a 401(k). You decide how many pre-tax dollars you want withheld from each paycheck, and earnings grow tax free.

Eligible HSA expenses include deductibles and coinsurance, as well as health expenses that are eligible to be paid with a medical flexible spending account.

HSA Eligibility

To be eligible for the HSA the following things must apply to you:

- » You're not participating in or covered by a flexible spending account (FSA) or HRA or their balances will be $0 on or before June 30.
- » You're not covered by another health plan (unless it's another HSA-qualified plan).
- » You're not covered by Medicare or TRICARE.
- » You're not a dependent of another taxpayer.

Banking with HealthEquity

PEHP has an arrangement with HealthEquity to handle your HSA. The State of Utah will make your HSA contributions through PEHP to HealthEquity into your account. You are responsible for the management of your HSA funds once they are in the account.

For More Information

For more information about HSAs go to: www.pehp.org/thestarplan, www.healthequity.com/stateofutah, www.ustreas.gov, or www.irs.gov.

Learn more: www.pehp.org/thestarplan | www.healthyequity.com/stateofutah

The PEHP STAR Plan (HSA-Qualified)

SUMMIT CARE*

ADVANTAGE CARE*

PREFERRED CARE**

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions. * Services received by a non-contracted provider will be paid at a percentage of PEHP's Allowed Amount (AA). You will be responsible for your assigned coinsurance and deductible (if applicable). You will also be responsible for any amounts billed by a non-contracted provider in excess of PEHP's Allowed Amount. There is no Out-of-Pocket Maximum for services received from a non-contracted provider.

	YOU PAY	
	Contracted Provider	**Non-Contracted Provider** *You may be balance billed. See Page 9 for explanation*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible	$1,500 single plan $3,000 double or family plan	Same as using a contracted provider *See Above for Additional Information **See Below for Additional Information
Plan Year Out-of-Pocket Maximum *Includes amounts applied to deductible and prescription drugs*	$2,500 single plan $5,000 double plan $7,500 family plan	No Out of Network Out-of-Pocket Maximum *See Above for Additional Information **See Below for Additional Information
Maximum Lifetime Benefit	None	None
Pre-existing Condition Waiting Period *Does not apply to any individuals up to age 19*	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage
**Applicable deductibles and coinsurance for services provided by a non-contracted provider will apply to your in-network plan year deductible and Out-of- Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, coinsurance amounts for non-contracted providers will still apply.		
INPATIENT FACILITY SERVICES		
Medical and Surgical | *Requires pre-authorization*	20% of AA after deductible	40% of AA after deductible
Skilled Nursing Facility | *Non-custodial* *Up to 60 days per plan year. Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Hospice | *Up to 6 months in a 3-year period. Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Rehabilitation *Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Mental Health | *Requires pre-authorization*	20% of AA after deductible	40% of AA after deductible
Substance Abuse | *Requires pre-authorization*	20% of AA after deductible	40% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of AA after deductible	40% of AA after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of AA after deductible	20% of AA after deductible
Emergency Room *Medical emergencies only, as determined by PEHP*	20% of AA after deductible	20% of AA after deductible
Urgent Care Facility	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of AA after deductible	40% of AA after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis with non-contracted providers requires pre-authorization*	20% of AA after deductible	40% of AA after deductible
Physical and Occupational Therapy *Requires pre-authorization after 12 visits*	20% of AA after deductible	40% of AA after deductible
PROFESSIONAL SERVICES		
Inpatient Physician Visits	20% of AA after deductible	40% of AA after deductible
Surgery and Anesthesia	20% of AA after deductible	40% of AA after deductible
Primary Care Office Visits and Office Surgeries	20% of AA after deductible	40% of AA after deductible
Specialist Office Visits and Office Surgeries	20% of AA after deductible	40% of AA after deductible
Emergency Room Specialist	20% of AA after deductible	20% of AA after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of AA after deductible	40% of AA after deductible
Immunizations	No charge	40% of AA after deductible
Mental Health and Substance Abuse *No pre-authorization required for outpatient services. Inpatient services require pre-authorization*	**Outpatient:** 50% of AA after deductible **Inpatient:** 20% of AA after deductible	**Outpatient:** 70% of AA after deductible **Inpatient:** 40% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
PRESCRIPTION DRUGS		
Retail Pharmacy | *Up to 30-day supply*	**Preferred generic:** $10 copayment after deductible **Preferred brand name:** 25% of discounted cost after deductible. $25 minimum, no maximum copayment **Non-preferred:** 50% of discounted cost after deductible. $50 minimum, no maximum copayment	Plan pays up to the discounted cost after deductible, minus the applicable copayment. Member pays any balance
Mail-Order | *90-day supply*	**Preferred generic:** $20 copayment after deductible **Preferred brand name:** 25% of discounted cost after deductible. $50 minimum, no maximum copayment **Non-preferred:** 50% of discounted cost after deductible. $100 minimum, no maximum copayment	Plan pays up to the discounted cost after deductible, minus the applicable copayment. Member pays any balance
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. No maximum copayment. **Tier B:** 30% of AA after deductible. No maximum copayment.	Plan pays up to the discounted cost after deductible, minus the applicable copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. No maximum copayment. **Tier B:** 30% of AA after deductible. No maximum copayment.	40% of AA after deductible
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. $150 maximum copayment. **Tier B:** 30% of AA after deductible. $225 maximum copayment.	Not covered
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge after deductible, up to $4,000 per adoption	No charge after deductible, up to $4,000 per adoption
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of AA after deductible
Allergy Serum	20% of AA after deductible	40% of AA after deductible
Chiropractic Care | *Up to 10 visits per plan year*	20% of AA after deductible	40% of AA after deductible
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require pre-authorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	20% of AA after deductible	40% of AA after deductible
Medical Supplies	20% of AA after deductible	40% of AA after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires pre-authorization and Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Infertility Services *Select services only. See the Master Policy*	50% of AA after deductible	70% of AA after deductible
Injections *Requires pre-authorization if over $750*	20% of AA after deductible	40% of AA after deductible
Temporomandibular Joint Dysfunction *Up to $1,000 lifetime maximum*	50% of AA after deductible	70% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

Traditional (Non-HSA)

SUMMIT CARE

ADVANTAGE CARE

PREFERRED CARE

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions. * Services received by a non-contracted provider will be paid at a percentage of PEHP's Allowed Amount (AA). You will be responsible for your assigned coinsurance and deductible (if applicable). You will also be responsible for any amounts billed by a non-contracted provider in excess of PEHP's Allowed Amount. There is no Out-of-Pocket Maximum for services received from a non-contracted provider.

	YOU PAY	
	Contracted Provider	**Non-Contracted Provider** *You may be balance billed. See Page 9 for explanation*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *In and Out of Network Deductibles are combined*	$250 per individual, $500 per family	Same as using a contracted provider *See Above for Additional Information **See Below for Additional Information
Pharmacy Deductible	$100 per individual, $200 per family	Not applicable
Plan year Out-of-Pocket Maximum	$2,500 per individual $5,000 per double $7,500 per family	No Out-of-Pocket Maximum *See Above for Additional Information **See Below for Additional Information
Pharmacy Out-of-Pocket Maximum *Does not apply to non-preferred drugs*	$3,000 per individual	Not applicable
Specialty Drug Out-of-Pocket Maximum, office/outpatient *Separate yearly out-of-pocket maximum*	$3,600 per individual	No Out-of-Pocket Maximum
Maximum Lifetime Benefit	None	None
Pre-existing Condition Waiting Period *Does not apply to any individuals up to age 19*	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage	9-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage
**Applicable deductibles and coinsurance for services provided by a non-contracted provider will apply to your in-network plan year deductible and Out-of- Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, coinsurance amounts for non-contracted providers will still apply.		
INPATIENT FACILITY SERVICES		
Medical and Surgical | *Requires pre-notification*	20% of AA after deductible	40% of AA after deductible
Skilled Nursing Facility | *Non-custodial* *Up to 60 days per plan year. Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Hospice | *Up to 6 months in a 3-year period. Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Rehabilitation *Requires pre-authorization through Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Mental Health *Requires pre-authorization*	20% of AA after deductible	40% of AA after deductible
Substance Abuse *Requires pre-authorization*	20% of AA after deductible	40% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of AA after deductible	40% of AA after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of AA after deductible	20% of AA after deductible
Emergency Room *Medical emergencies only, as determined by PEHP*	20% of AA minimum $150 copayment per visit	20% of AA minimum $150 copayment per visit
Urgent Care Facility	$45 copayment per visit **Preferred Care only:** University of Utah Medical Group Urgent Care Facility: $50 copayment per visit	40% of AA after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of AA after deductible	40% of AA after deductible
Chemotherapy, Radiation, and Dialysis	20% of AA after deductible	40% of AA after deductible *Dialysis with non-contracted providers requires pre-authorization*
Physical and Occupational Therapy *Requires pre-authorization after 12 visits*	Applicable office copayment per visit	40% of AA after deductible
PROFESSIONAL SERVICES		
Inpatient Physician Visits	Applicable office copayment per visit	40% of AA after deductible
Surgery and Anesthesia	20% of AA after deductible	40% of AA after deductible
Primary Care Office Visits and Office Surgeries	$25 copayment per visit **Preferred Care only:** University of Utah Medical Group Primary Care Office Visits: $50 copayment per visit	40% of AA after deductible
Specialist Office Visits and Office Surgeries,	$35 copayment per visit **Preferred Care only:** University of Utah Medical Group Specialist Office Visit: $50 copayment per visit	40% of AA after deductible
Emergency Room Specialist	$35 copayment per visit	$35 copayment per visit
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	20% of AA after deductible	40% of AA after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of AA after deductible	40% of AA after deductible
Mental Health and Substance Abuse *No pre-authorization required for outpatient services. Inpatient services require pre-authorization*	**Outpatient:** $35 copayment per visit **Inpatient:** Applicable office copayment per visit	**Outpatient:** 40% of AA after deductible **Inpatient:** 40% of AA after deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
PRESCRIPTION DRUGS		
Retail Pharmacy | *Up to 30-day supply*	**Preferred generic:** $10 copayment after deductible **Preferred brand name:** 25% of discounted cost after deductible. $25 minimum, no maximum copayment **Non-preferred:** 50% of discounted cost after deductible. $50 minimum, no maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment. Member pays any balance
Mail-Order | *90-day supply*	**Preferred generic:** $20 copayment after deductible **Preferred brand name:** 25% of discounted cost after deductible. $50 minimum, no maximum copayment **Non-preferred:** 50% of discounted cost after deductible. $100 minimum, no maximum copayment	Plan pays up to the discounted cost, minus the applicable copayment. Member pays any balance
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. No maximum copayment **Tier B:** 30% of AA after deductible. No maximum copayment	Plan pays up to the discounted cost, minus the preferred copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. No maximum copayment **Tier B:** 30% of AA after deductible. No maximum copayment	40% of AA after deductible
Specialty Medications, through specialty vendor Accredo | *Up to 30-day supply*	**Tier A:** 20% of AA after deductible. $150 maximum copayment **Tier B:** 30% of AA after deductible. $225 maximum copayment	Not covered
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge after deductible, up to $4,000 per adoption	No charge after deductible, up to $4,000 per adoption
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of AA after deductible
Allergy Serum	20% of AA after deductible	40% of AA after deductible
Chiropractic Care | *Up to 10 visits per plan year*	Applicable office copayment per visit	40% of AA after deductible
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require pre-authorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	20% of AA after deductible	40% of AA after deductible
Medical Supplies	20% of AA after deductible	40% of AA after deductible
Home Health/Skilled Nursing | *Up to 60 visits per plan year. Requires pre-authorization and Medical Case Management*	20% of AA after deductible	40% of AA after deductible
Infertility Services | *Select services only. See the Master Policy*	50% of AA after deductible	70% of AA after deductible
Injections | *Requires pre-authorization if over $750*	20% of AA after deductible	40% of AA after deductible
Temporomandibular Joint Dysfunction *Up to $1,000 lifetime maximum*	50% of AA after deductible	70% of AA after deductible

***Some services on your plan are payable at a reduced benefit of 50% of Allowed Amount or 30% of Allowed Amount. These services do not apply to any Out-of-Pocket Maximum. Deductible may apply. Refer to the Advantage, Summit, or Preferred Care Provider Plan Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.*

Non-contracted providers may charge more than the Allowed Amount unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

Important Notice: Utah Basic Plus is administered by its own Master Policy. The benefits are very different from the Traditional or STAR plans. Find details such as limitations and exclusions on pages 54-65 in this summary or refer to the Utah Basic Plus Master Policy.

You may not select Utah Basic Plus unless you are currently on The STAR Plan.

If you choose Utah Basic Plus, you must enroll in an HSA-qualified plan the next enrollment period.

Utah Basic Plus (HSA-Qualified)

SUMMIT CARE

ADVANTAGE CARE

PREFERRED CARE

Refer to the Utah Basic Plus Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions. * Services received by a non-contracted provider will be paid at a percentage of PEHP's Allowed Amount (AA). You will be responsible for your assigned coinsurance and deductible (if applicable). You will also be responsible for any amounts billed by a non-contracted provider in excess of PEHP's Allowed Amount. There is no Out-of-Pocket Maximum for services received from a non-contracted provider.

YOU PAY

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Medical Deductible	$3,000 single plan, $6,000 double or family plan	Same as using a contracted provider *See Above for Additional Information **See Below for Additional Information
Plan Year Out-of-Pocket Maximum *Includes Deductibles and Coinsurance*	$6,050 single plan, $12,100 double or family plan	No Out-of-Network Out-of-Pocket Maximum *See Above for Additional Information **See Below for Additional Information
Maximum Annual Benefit	None	None
Pre-existing Condition Waiting Period *Does not apply to any individual up to age 19*	12-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage	12-month Waiting Period— waived or reduced with evidence of prior Creditable Coverage
**Applicable deductibles and coinsurance for services provided by a non-contracted provider will apply to your in-network plan year deductible and Out-of- Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, coinsurance amounts for non-contracted providers will still apply.		
INPATIENT FACILITY SERVICES		
Medical and Surgical | *Requires Pre-notification*	30% of AA after Deductible	50% of AA after Deductible
Skilled Nursing Facility *Non-custodial. Up to 30 days maximum per plan year. Requires Pre-authorization and Medical Case Management*	30% of AA after Deductible	50% of AA after Deductible
Hospice | *Up to six months in a three-year period. Requires Pre-authorization and Medical Case Management*	30% of AA after Deductible	50% of AA after Deductible
Rehabilitation | *Requires Pre-authorization and Medical Case Management. Up to 30 days maximum per plan year*	30% of AA after Deductible	50% of AA after Deductible
Mental Health/ Substance Abuse *Requires Pre-authorization. Up to 30 days maximum per plan year*	30% of AA after Deductible	50% of AA after Deductible

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	30% of AA after Deductible	50% of AA after Deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	30% of AA after Deductible	30% of AA after Deductible
Emergency Room *Medical emergencies only, as determined by PEHP.*	30% of AA after Deductible.	30% of AA after Deductible
Urgent Care Facility	30% of AA after Deductible	50% of AA after Deductible
Diagnostic Tests, X-rays	30% of AA after Deductible	50% of AA after Deductible
Chemotherapy, Radiation, and Dialysis	30% of AA after Deductible	50% of AA after Deductible
Physical, Occupational, and Speech Therapy *Limited to 20 visits per plan year for all therapy types combined.* *Pre-authorization required only for home visits*	30% of AA after Deductible	50% of AA after Deductible
PROFESSIONAL SERVICES		
Inpatient Physician Visits	30% of AA after Deductible	50% of AA after Deductible
Emergency Room Physician Visits	30% of AA after Deductible	30% of AA after Deductible
Surgery and Anesthesia	30% of AA after Deductible	50% of AA after Deductible
Primary Care Office Visits	30% of AA after Deductible	50% of AA after Deductible
Specialist Office Visits	30% of AA after Deductible	50% of AA after Deductible
Diagnostic Tests, X-rays	30% of AA after Deductible	50% of AA after Deductible
Mental Health*/Substance Abuse *No Pre-authorization required for outpatient service.* *Inpatient services require Pre-authorization*	30% of AA after Deductible	50% of AA after Deductible
PRESCRIPTION DRUGS		
Retail Pharmacy | *Up to 30-day supply*	**Preferred generic:** 30% of discounted cost after Deductible **Preferred brand name:** 30% of discounted cost after Deductible	Plan pays 50% of the discounted cost after deductible. Member pays any balance
Specialty Injectible Medications, office/outpatient *Up to 30-day supply*	30% of AA after Deductible. No maximum Coinsurance	Not covered
Specialty Injectible Medications, through specialty vendor Accredo *Up to 30-day supply*	30% of AA after Deductible. No maximum Coinsurance	Not covered
Specialty Oral Medications, through specialty vendor Accredo *Up to 30-day supply*	30% of AA after Deductible. No maximum Coinsurance	Not covered

*Life assistance counseling through Blomquist Hale Counseling Group is not available for members enrolled in Utah Basic Plus.

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

	Contracted Provider	Non-Contracted Provider *You may be balance billed. See Page 9 for explanation*
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	30% after Deductible, up to $4,000 per adoption	30% after Deductible, up to $4,000 per adoption
Allergy Serum	30% of AA after Deductible	50% of AA after Deductible
Chiropractic Care	Not covered	Not covered
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require pre-authorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	30% of AA after Deductible	50% of AA after Deductible
Medical Supplies	30% of AA after Deductible	50% of AA after Deductible
Home Health/Skilled Nursing *Up to 30 visits per plan year.* *Requires Pre-authorization and Medical Case Management*	30% of AA after Deductible	50% of AA after Deductible
Infertility Services	Not covered	Not covered
Injections *Requires Pre-authorization if over $750*	30% of AA after Deductible	50% of AA after Deductible
Temporomandibular Joint Dysfunction	Not covered	Not covered
Sleep Studies	Not covered	Not covered
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	50% of AA after Deductible
Routine Physical Exams *1 visit per plan year*	No charge	50% of AA after Deductible
Pap Smear *1 visit per plan year*	No charge	50% of AA after Deductible
Mammogram *1 visit per plan year, age 40 and above*	No charge	50% of AA after Deductible
Routine Well-Child Exams	No charge	50% of AA after Deductible
Immunizations	No charge	50% of AA after Deductible
Routine Vision Exams *1 visit per plan year age 5-18*	30% of AA after Deductible	50% of AA after Deductible
Routine Hearing Exams	Not covered	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	30% of AA after Deductible	50% of AA after Deductible
Pediatric Dental Services** *Routine cleaning, exams, x-rays and fluoride.* *Two times per plan year. Age 3-18.* *Sealants once every five years. See Master Policy for details.*	30% of AA after Deductible	50% of AA after Deductible

**Payable only as secondary to a dental plan or if member does not have a separate dental plan.

AA = Allowed Amount

Non-contracted providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 9.

Eligibility, Enrollment & Coordination of Benefits

This section outlines the terms of eligibility for coverage under your plan.

Eligibility

The eligibility of Employees and eligible Dependents is determined based on the Employer's personnel policies and the Employee's representations made on their verified individual Enrollment form, which is a part of this contract. In addition, the only employees eligible for the Utah Basic Plus plan are new employees or employees currently enrolled in the STAR plan. Copies of Member's completed Enrollment forms are available upon request. Members who commit fraud or any other crime against PEHP are not eligible for Coverage.

Enrollment Period

You have 60 days from the date you become eligible for coverage to enroll you and your eligible dependents for coverage. The effective date of your coverage will be determined by your employer's personnel policies. For new State employees, this is your hire date.

Eligible employees have 60 days from the hire date to enroll in or decline a medical plan. During the first 30 days from the hire date, the employee may choose from all medical plan options.

After 30 days and up to day 60 from the hire date, the employee may only select an HSA-qualified plans. If that employee is ineligible for a Health Savings Account (HSA), the employee will be enrolled in the HSA-qualifed plan of his or her choosing, but the state's HSA contributions will be forfeit.

After 60 days, the employee is considered a late enrollee and will not be allowed to enroll in any of the medical or dental plan options. You and your dependents will have to wait until the next annual enrollment period to enroll.

Newly eligible dependents may be enrolled within 60 days from the date of birth, or placement in your home, or from the date of marriage. For such dependents, coverage will become effective on the date of birth, placement in home, or the date of marriage. If not enrolled within 60 days from the qualifying event, dependents will be considered late enrollees and must wait until the next annual enrollment period to enroll.

Late Enrollees

Late enrollees are not eligible to enroll until the employer's next annual enrollment period. They will be subject to any Pre-existing Condition (PEC) waiting period specified by the employer's health plan. Previous Creditable Coverage may be applied toward satisfying all or part of the PEC waiting period.

Special Enrollment

Late enrollees may enroll prior to the employer's next annual Enrollment by meeting the qualifications for special Enrollment. PEHP shall allow special Enrollment in the following circumstances::

1) LOSS OF OTHER COVERAGE

Eligible Employees and/or their eligible Dependents who do not initially enroll in Coverage may enroll at a time other than annual Enrollment only if:

1. The eligible Employee and/or their eligible Dependents declined to enroll in this Coverage due to the existence of other health plan Coverage; and
2. The eligible Employee and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 60 days after the date the other Coverage is lost.

Proof of loss of the other Coverage

Certificate of Creditable Coverage must be submitted to PEHP at the time of application. Proof of loss of other Coverage or other acceptable documentation, must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, PEHP will accept the following:

a. A letter from a prior employer indicating when group coverage began and ended;

b. Any other relevant documents that evidence periods of Coverage; or;

c. A telephone call from the other Insurer to PEHP verifying dates of Coverage.

2) FAMILY STATUS CHANGE

PEHP shall also allow you and/or your Dependents to enroll if you gain an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time you enroll your Dependents, you may also be enrolled. In the case of birth or adoption of a child, you may also enroll your spouse, even though he/she is not newly eligible as a Dependent. However, special

Eligibility, Enrollment & Coordination of Benefits

Enrollment is permitted only when the Enrollment takes place within 60 days of the marriage, birth, adoption or placement for adoption. PEHP must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in coverage. If a divorce decree is set aside by a court of competent jurisdiction, PEHP shall treat the Dependent(s) as eligible for re-Enrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.

3) LEGAL GUARDIANSHIP

You may enroll any unmarried, financially dependent children who are under age 26 that are placed under your or your spouse's legal guardianship within 60 days of receiving such legal guardianship.

Transfer of Coverage

If you transfer from one PEHP plan to another, or if your coverage is terminated and then later reinstated, plan provisions for limited benefits, yearly maximum benefits, and lifetime limits will be maintained and be continuous from the point of transfer or termination. If you have a break-in-coverage of 63 days or more, any Pre-existing condition exclusion period will apply, beginning with your new effective date. Coverage for dependents may be switched from one subscriber to another without completing a new Pre-existing condition exclusion period.

Certifications and Disclosure of Coverage

If you have prior Creditable Coverage, you must provide a Certification and Disclosure of Coverage, or other acceptable documentation of Creditable Coverage at the time of enrollment. If no Certification or other documentation of Creditable Coverage is provided, the Pre-existing condition exclusion period will automatically be applied.

PEHP shall provide a Certificate of Creditable Coverage to you or your dependents in the following circumstances:

- When a member loses active group coverage with PEHP;
- When a member loses COBRA coverage; or
- When a member requests a Certificate of Creditable Coverage from PEHP within 24 months of the date of termination of coverage.

Pre-existing Condition Waiting Period

No claims for services related to a Pre-existing condition will be paid during the Pre-existing condition waiting period applicable to your plan. However, if you have prior health coverage, without a break-in-coverage of 63 days or more (Creditable Coverage), the Pre-existing Condition Waiting Period will be reduced or waived depending on length of your prior Creditable Coverage. If you have had a break-in-coverage of 63 days or more, the coverage prior to the break will not be credited.

No Pre-existing Condition Waiting Period will be imposed upon pregnancy or upon any member under the age of 19.

Termination of Coverage

Coverage for a Member will terminate if the Member ceases to be eligible for the following reasons:

1. Termination of employment – Coverage will terminate at the end of last day of work, the end of the last day of Employer's payroll period or the end of the last day of the month, according to the Employer's internal policies.
2. Dependent child turns age 26 – Coverage will terminate at the end of the day prior to the 26th birthday.
3. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the day prior to the date on the court-signed divorce decree.
4. Death of Subscriber – Coverage will terminate at the end of last day of work, the end of the last day of Employer's payroll period or the end of the last day of the month, according to the Employer's internal policies.
5. Failure to make timely payment of rates to PEHP – Coverage will terminate at the end of the day through which previous payment has been received by PEHP.
6. Employer group terminates PEHP group coverage. The Subscriber may not terminate coverage for Dependents any time during the year unless one of the following conditions are met:
    a. Dependent enrolls in other group coverage;
    b. Commencement or termination of employment of Dependent;

Eligibility, Enrollment & Coordination of Benefits

c. A change from part-time to full-time status (or vice versa) by the Subscriber or the Dependent; or

d. A significant change in the health Coverage of the Subscriber, Subscriber's spouse or Dependent attributable to their employment.

It is the Subscriber's responsibility to make written notification when a Dependent is no longer eligible for Coverage. PEHP will not refund Payments made for ineligible Dependents. The Subscriber will be held responsible to reimburse PEHP for the claims processed beyond eligible service dates.

Pursuant to Section 76-6-521 of the Utah Code Annotated, anyone who fails to notify PEHP of Dependents ineligibility for Coverage is committing insurance fraud, a Class B Misdemeanor, punishable by fines or imprisonment.

PEHP shall have the right to deny claims, terminate any or all Coverages of a Member and seek reimbursement of claims paid upon the determination by PEHP that the Member has committed any of the following:

1. Fraud upon PEHP or Utah Retirement Systems;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of this Master Policy

Liability for Services After Termination

PEHP is never responsible for claims incurred after the termination date of coverage, regardless of when the condition arose and despite care or treatment anticipated or already in progress.

Coordination of Benefits

COORDINATION OF BENEFITS WITH OTHER CARRIERS

The Coordination of Benefits (COB) provision applies when you or your dependents have healthcare coverage under more than one health benefit plan. The purpose of coordinating benefits is to avoid duplication of insurance payments. It involves determining which insurer is required to pay benefits as the primary payer, which insurer must pay as the secondary payer and so on, until all insurers are considered in the correct payment order.

You must inform PEHP of other medical and/or dental coverage in force by completing a duplicate coverage form. If applicable, you may be required to submit court orders or decrees. You must also keep PEHP informed of any changes in the status of the other coverage.

COORDINATION OF BENEFITS RULES

When PEHP is the primary plan, eligible benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits. When PEHP is the second plan, PEHP calculates the amount of eligible benefits it would normally pay in the absence of other coverage, including the application of credits to any policy maximums, and applies the payable amount to unpaid covered charges after eligible benefits have been paid by the primary plan. This amount includes deductibles and copayments you may owe. PEHP will use its own deductible and copayments to calculate the amount it would have paid in the absence of other coverage. In no event will PEHP pay more than the member is responsible to pay after the primary carrier has paid the claim. COB will be administered in accordance with Utah State Law.

Continuation of Coverage

COBRA Continuation Coverage

If you are an Employee of an Employer with 20 or more Employees, you and your Dependents may be eligible to continue health coverage at group rates under COBRA. This coverage, however, is only available when coverage is lost due to certain specific events. If you experience a termination of coverage due to a COBRA-qualifying event and you provide proper notice, you have 60 days from either the termination of coverage or date of the COBRA notice to elect to enroll in COBRA continuation coverage. In no event will COBRA extend for more than 36 months. PEHP administers COBRA continuation coverage in accordance with federal law. Refer to the COBRA Notice section in this Benefits Summary or the PEHP Master Policy for details regarding your COBRA continuation coverage rights.

PEHP Basic Care

If a Member is eligible to enroll in federal COBRA or State Mini-Cobra ("COBRA") coverage due to a concurrent loss of coverage and a qualifying event, that member may instead elect to enroll in a lower cost PEHP Basic Plan Coverage ("Basic Plan") as an alternative to COBRA. The Basic Plan does not extend any COBRA rights or benefits. Like COBRA, a member has 60 days from the COBRA qualifying event to enroll in the Basic Plan. The right to elect the Basic Plan coverage also applies to any spouse or dependent coverage, including a surviving spouse or dependent whose coverage under the member's policy terminates by reason of the member's death. The Basic Plan will be administered in accordance with Utah State Law.

Conversion

Under certain circumstances, if you are no longer eligible for group coverage or continuation coverage, you may be eligible to obtain Conversion coverage. If eligible, you must apply for Conversion coverage within 60 days from the termination date of your group coverage or continuation coverage. PEHP administers Conversion coverage according to Utah State Law. Refer to the PEHP Master Policy for details regarding conversion coverage.

Subrogation

Subrogation

You agree to seek recovery from any person who may be obligated to pay damages arising from occurrences or conditions caused by the person for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of your efforts to recover from those person(s). If you do not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on your behalf.

In the event that Eligible Benefits are furnished to you for bodily injury or illness, you shall reimburse PEHP with respect to your right (to the extent of the value of the benefits paid) to any claim for bodily injury or illness, regardless of whether you have been "made whole" or have been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for your claims for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to any attorney fees or costs you choose to incur in securing the amount of the claim.

ACCEPTANCE OF BENEFITS AND NOTIFICATION

Acceptance of the benefits hereunder shall constitute acceptance of PEHP's right to Subrogation rights as explained above. You are required to do the following:

- Promptly notify PEHP of all possible subrogation/restitution situations;
- Help PEHP or PEHP's designated agent to assert its subrogation/restitution interest;
- Not settle any dispute with a third party without protecting PEHP's subrogation/restitution interest; and
- Sign any papers required to enable PEHP to assert its subrogation/restitution interest.

RECOUPMENT OF BENEFIT PAYMENT

In the event you impair PEHP's Subrogation rights under this contract through failure to notify PEHP of potential liability, settling a claim with a responsible party without PEHP's involvement, or otherwise, PEHP reserves the right to recover from you the value of all benefits paid by PEHP on your behalf resulting from the party's acts or omissions. No judgment against any party will be conclusive between you and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

Claims, Submission, and Appeals

Claims Submission

When you use a contracted provider, he/she will submit the claims directly to PEHP. PEHP will pay the claim directly to the contracted provider. It is the contracted provider's responsibility to file the claim within 12 months from the date of service. Claims denied for untimely filing are not your responsibility except under the following conditions:

- When PEHP becomes the secondary payor, you are responsible to ensure timely filing from all providers. Claims must be submitted to PEHP within 15 months from the date of service to be eligible.
- When you provided incorrect information regarding medical plan coverage to a contracted provider.

Claims denied for untimely filing in these instances are your responsibility.

When a non-contracted provider is used, it is your responsibility to ensure that the claim is filed promptly and properly. PEHP accepts paper and electronic claims. Claims that are not received within 12 months from the date of service will be denied. You are responsible to pay the entire claim. If you want benefits paid directly to the non-contracted provider, an Assignment of Benefits form allowing PEHP to do so must be signed.

Claims may be submitted electronically, or mailed to:

PEHP
Claims Division
560 East 200 South
Salt Lake City, UT 84102-2004

Requests for Information

PEHP will take appropriate steps to properly identify a member calling for claims information. It is your responsibility to understand benefit limitations, pre-authorization/pre-notification requirements, exclusions and choice of providers, which may apply to your circumstances. If you are in doubt as to benefit information, consult PEHP.

REQUEST FOR INFORMATION BY A NON-SUBSCRIBER PARENT

Upon receiving appropriate documentation, PEHP may provide a person with court-ordered physical custody with information regarding claims payment for a covered Dependent.

Claims, Submission, and Appeals

Claims Appeal Process

If a Member disagrees with a PEHP decision regarding benefits, the Member may request a full and fair review by completing the PEHP Appeal form located on each explanation of benefit statement, or available online at pehp.org, and returning the form to PEHP within 180 days after PEHP's initial determination. If the appeal form is not received by PEHP within 180 days, the appeal shall be denied. PEHP shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist PEHP in making a determination on the appeal. Requests for a review of claims should be sent to one of the following addresses:

Mail

PEHP Appeals and Policy Management Department
P.O. Box 3836
Salt Lake City, UT 84110-3836

Fax: 801-320-0541

PEHP shall review and investigate the appeal. If PEHP requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have 45 days to provide the information to PEHP. Unless an expedited appeal or unless PEHP requests additional information from the Member, PEHP shall decide the appeal and inform the Member of the decision within 60 days from its receipt of the appeal form. PEHP's investigation shall include a review by the Executive Director of Utah Retirement Systems in accordance with Utah Code Annotated § 49-11-613(1)(c).

In accordance with federal law, if PEHP's decision on the appeal involved a medical judgment, a member may request an external review of PEHP's decision by completing PEHP's external review form and returning the form to PEHP. The member shall pay $25 for filing a request for an external review unless the member provides evidence to PEHP that they are indigent (unable to pay). The request for external review and the $25 fee must be received by PEHP within 30 days of the date of PEHP's decision. Following the external reviewer's decision, PEHP shall notify the member of the decision. If PEHP's original decision is overturned by the external reviewer, PEHP shall refund the $25 filing amount to the Member.

If PEHP's decision on the appeal did not involve a medical judgment, or if a member contests the decision of the external reviewer, a member may, within 30 days of the denial, file a written request for a formal administrative hearing before the Utah State Retirement Board's hearing officer, in accordance with the procedure set forth in Utah Code Annotated § 49-11-613. The Member must file the petition to the hearing officer on a standard form provided by and returned to the Retirement Office. Once the hearing process is complete, the hearing officer will prepare an order for the signature of the Utah Retirement Board. See the Master Policy for a more complete list of definitions. Find the Master Policy at www.pehp.org or call PEHP.

Definitions

See the Master Policy for a more complete list of definitions. Find the Master Policy at www.pehp.org or call PEHP.

BALANCE BILL
The dollar amount between the billed and Allowed Amount that the member is responsible to pay when services are received from a non-contracted provider.

CONTRACTED PROVIDER
A medical professional or medical facility who has contractually agreed to provide care to PEHP members for a specific fee.

COPAYMENT
The portion of the cost of eligible benefits that a member is obligated to pay, including Deductibles and coinsurance. A Copayment may be either a fixed dollar amount or a percentage of the maximum allowable fee.

CREDITABLE COVERAGE
Any comprehensive health insurance plan coverage such as: a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act; Chapter 55 of Title 10 of the U.S.C.; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the U.S.C.; a public health plan; or, a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

DEDUCTIBLE
The amount you pay for eligible charges before any benefits will be paid by PEHP.

DEPENDENT
"Dependent" means:

1. The Subscriber's lawful spouse. Adequate legal documentation may be required.
2. Adult designee and their Dependents as defined by the Employer (if applicable).
3. Children or stepchildren of the Subscriber up to the age of 26 who have a Parental Relationship with the Subscriber. Adequate legal documentation may be requested.
4. Legally adopted children, who are adopted prior to turning 18 years old, foster children up to age 19, and children through legal guardianship up to the age of 26 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed.)
5. Children who are incapable of self support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber's federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber's Coverage continuing in effect. Periodic documentation is required. Subscriber must furnish written notification of the disability to PEHP no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning:
   a. The condition that led to the Dependent's physical or mental disability;
   b. Income, if any, earned by the Dependent; and
   c. The capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities.

   If proof of disability is approved, the Dependent's Coverage may be continued as long as he/she remains Totally Disabled and unable to earn a living, and as long as none of the other causes of termination occur.

   At the time of a Dependent's approval for continued PEHP Coverage, PEHP shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent's continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent's Coverage will terminate on the renewal date.
6. When you or your lawful spouse are required by a court or administrative order to provide health coverage for a child, the child will be enrolled in your coverage according to PEHP guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions and will be subject to applicable PEC waiting period. The effective date for a qualified order will be the start date indicated in the order.

Definitions

7. In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage but may be eligible to convert to a COBRA plan. PEHP will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree.
8. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under PEHP.
9. Dependent does not include an unborn fetus.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

ENROLLMENT

The process whereby an employee makes written or electronic application for coverage through PEHP, subject to specified time periods and plan provisions.

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN

Those services, supplies, devices, or pharmaceutical (drug) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as solely determined by PEHP.

FDA APPROVED

Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

LIFE-THREATENING

The sudden and acute onset of an illness or injury where delay in treatment would jeopardize your life or cause permanent damage to your health such as, but not limited to, loss of heartbeat, loss of consciousness, cessation or severely obstructed breathing, massive and uncontrolled bleeding. A determination of Life-threatening will be made by PEHP on the basis of the final diagnosis and medical review of the records.

MEDICALLY NECESSARY / MEDICAL NECESSITY

Any healthcare services, supplies or treatment provided for an illness or injury which is consistent with your symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for your or the providers convenience. However, such healthcare services must be appropriate with regard to standards of good medical practice in the Salt Lake County and could not have been omitted without adversely affecting your condition or the quality of medical care you received as determined by established medical review mechanisms, within the scope of the provider's licensure, and/or consistent with and included in policies established and recognized by PEHP. Any medical condition, treatment, service, equipment, etc. specifically excluded in the PEHP Master Policy is not an eligible benefit regardless of Medical Necessity.

PARENTAL RELATIONSHIP

The relationship between a natural child or stepchild and a parent while the child or stepchild is Dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the subscriber stepparent is terminated for any reason.

Definitions

PRE-AUTHORIZATION/PRIOR AUTHORIZATION
The administrative process whereby you and your provider can learn, in advance of treatment, the level of benefits provided by the PEHP Master Policy for the proposed treatment plan. The process, prior to service, that you and the treating provider must complete in order to obtain authorization for specified benefits of the PEHP Master Policy which may be subject to limitations and to receive the maximum benefits of the PEHP Master Policy for hospitalization, surgical procedures, Durable Medical Equipment, or other services as required. Pre-authorization does not guarantee payment should coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

PRE-NOTIFICATION
The process the member must follow in order to notify PEHP of any impending hospital admission or other medical procedure as required by the PEHP Master Policy.

PREFERRED DRUG LIST
A list of selected prescription medication approved by PEHP for coverage.

SUBSCRIBER
An employee of an employer offering coverage through PEHP who has enrolled in coverage with PEHP.

URGENT CONDITION
An acute health condition with a sudden, unexpected onset, which is not Life-threatening but which poses a danger to the health of the member if not attended by a physician within 24 hours: e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

Notices

Notice of COBRA Rights

The Public Employees Health Program (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.

Notices

»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 qualifying events:

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

»Dependent Children

A Dependent child of an employee covered by PEHP and where 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 qualifying events:

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

Notices

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.

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. 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.

Notices

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.

Notices

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 2013-14 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 April 14, 2003

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. This notice describes how we protect the confidentiality of the personal information we receive. 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
- 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.

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.

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 privacy practices, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law.

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.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Using Your Medical Benefits

This document is a summary only. It is not a contract. The PEHP Master Policy is the contract between you and your dependents and PEHP. Refer to the PEHP Master Policy for a full and complete description of your benefits.

Member Identification Card

You will receive up to two identification cards when you first enroll with PEHP. The identification cards are used for prescription drug, medical, dental, and out of state benefits (see page 39 or 51 for Coverage Outside of Utah). You and your dependents will be asked to present this card when you fill prescriptions and when you receive medical care. The information on the card allows your provider to bill both you and PEHP correctly. New cards will not be issued every year, but only when the information on the card changes. If you lose your card or need additional cards for dependents, you may request them by calling PEHP.

Contracted Providers

Providers who are contracted with your network have agreed to accept a Allowed Amount for each service performed when seeing PEHP members. You are responsible to pay only the copayment amount listed in the benefits grid. The contracted provider will accept the amount PEHP paid, along with your copayment amount, as payment in full for the claim.

Provider Directories

Refer to the PEHP Provider Directories at www.pehp.org for the most current listing of providers and facilities contracted with PEHP for your network. You may request a printed copy of the Provider Directories by calling PEHP.

Non-Contracted Providers

Providers who are not contracted with your network have not agreed to accept PEHP's Allowed Amount. This means that you will be responsible to pay the copayment amount listed in the benefits grid, as well as the difference between the non-contracted providers' billed charge and the PEHP allowable amount.

Pre-notification and Pre-authorization

Certain medical services require Pre-notification or Pre-authorization by PEHP before being eligible for payment. While many Contracted and non-Contracted Providers will generally Pre-authorize or Pre-notify on your behalf, it is your responsibility to ensure that PEHP has received notice and/or granted approval for any service requiring Pre-notification or Pre-authorization prior to the services being received. If you do not Pre-authorize or Pre-notify services that require such approval, benefits may be reduced or denied by PEHP.

Failure to Pre-notify inpatient hospitalization for elective admissions will result in a reduction of benefits of $200 per day for each day not Pre-notified. Failure to Pre-notify non-elective admissions will result in a reduction of benefits of $200 per day for each day after the third day that is not pre-notified. No benefits are payable for Mental Health or Substance Abuse admissions without Pre-authorization.

All inpatient hospitalizations for Mental Health or Substance Abuse require Pre-authorization.

The following services require Pre-notification by calling PEHP Customer Service:

» All inpatient hospitalizations

» All skilled nursing facility admissions

» All inpatient hospital rehabilitation admissions

The following services require verbal Pre-authorization by calling PEHP Customer Service:

» Any inpatient maternity stay that exceeds 48 hours following a vaginal delivery or 96 hours following delivery by Cesarean section

The following is a list of the most common services requiring written Pre-authorization. It is not all inclusive. Call PEHP if you have any questions regarding Pre-authorization:

» Eligible dental procedures performed in an outpatient facility for patients 6 years of age and older

» Organ or tissue transplants

» Surgery that may be partially or wholly Cosmetic

» Coronary CT angiography

» Surgery performed in conjunction with obesity Surgery

» Implantation of artificial Devices

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Using Your Medical Benefits

- New and Unproven technologies
- Cochlear implants
- Molecular diagnostics (genetic testing)
- Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days, except for sleep disorder equipment and oxygen
- Botox injections
- Maxillary/Mandibular bone or Calcitite augmentation Surgery
- All out-of-state, out-of-network surgeries/ procedures or inpatient admissions that are not Urgent or Life-threatening
- Pelvic floor therapy
- Wound care, except for the diagnosis of burns
- Home health and Hospice Care
- Hyperbaric oxygen treatments
- Intrathecal pumps
- Spinal cord stimulators
- Surgical Procedures utilizing robotic assistance
- Implantable medications, excluding contraception
- Certain prescription and Specialty Drugs
- Continuous glucose monitoring Devices and supplies
- Jaw surgery
- Dialysis when using non-Contracted Providers
- Breast pumps – Hospital grade
- Human pasteurized milk
- Physical or occupational therapy after 8 combined visits
- Speech therapy after initial evaluation
- Stereotactic radiosurgery
- Magnetoencephalography (MEG)/ magnetic source imaging
- Voice therapy
- Breast reconstruction surgery
- Virtual colonoscopy
- Transanal endoscopic microsurgery
- Artificial ankle prosthetic
- Endovenous ablation therapy (Radiofrequency or laser)
- Manipulation under anesthesia
- Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation)
- Any Surgery for Obstructive Sleep Apnea
- Chelation therapy
- Video EEG Monitoring (VEEG)

Coverage Outside of Utah

PEHP has made an arrangement with the MultiPlan network of providers and facilities to help reduce your out-of pocket costs when you receive care outside of Utah. MultiPlan providers are considered contracted providers for the purpose of claims payment. The MultiPlan network is only available to the following PEHP Members: 1) Members who are living outside the State of Utah (Members who are living outside the State of Utah must notify PEHP of their out-of-state address prior to receiving Coverage); 2) Members traveling outside the State of Utah who are in need of urgent or life-threatening services while traveling (Coverage is excluded for services outside the State of Utah when a Member is traveling for the purpose of seeking medical care or treatment.); or 3) Members that require medical services that are not available in Utah and that have been Pre-authorized by PEHP. Locate a contracted provider outside of Utah at www.multiplan.com, or by calling 800-922-4362. You must show your PEHP Medical Identification card at the time of service, otherwise, PEHP can't guarantee discounts or in-network benefits.

The National Access Program is not available to Members enrolled in Conversion or PEHP Basic Care.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Using Your Medical Benefits

Urgent Care Condition

PEHP considers an urgent condition as an illness or injury that is not life-threatening, but requires medical attention within 24 hours.

Services to treat an urgent condition by a non-contracted provider in Utah will be allowed up to the Maximum Allowable fee and paid by PEHP at the amount specified for Non-Contracted Providers in the Members applicable benefit grid.

Services to treat an urgent condition by a non-contracted provider outside of Utah will be allowed up to the Allowed Amount by State average as determined by the National Access Program, or negotiated fees, and paid by PEHP at the amount specified for Non-Contracted Providers in the Members applicable benefit grid.

Life-Threatening Emergencies in Utah

Medical services to treat a Life-threatening condition from a non-Contracted Provider in Utah will be allowed up to the Allowed Amount and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary. In the case of in-patient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with PEHP's Medical Case Management.

Life-Threatening Emergencies Outside of Utah

Medical services to treat a Life-threatening condition from a non-Contracted Provider outside of Utah will be allowed by PEHP at the Allowed Amount by State average as determined by the National Access program, or negotiated fees and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary. In the case of in-patient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with PEHP's Medical Case Management.

Emergency Transportation

Ambulance services are payable only in the case of medical emergencies and only for transportation to the nearest facility capable of treating your condition, or when you cannot safely be transported by other means. See the limitations and exclusions section of this Benefit Summary for more information.

Medical Case Management

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager will work with the Member, the Member's family, Providers, outside consultants and others to coordinate a comprehensive, medically appropriate treatment plan.

Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines.

PEHP, at its own discretion, may require a Member to obtain Pre-authorization for any and all benefits in coordination with Medical Case Management, if PEHP has determined such action is warranted by the Member's claims history.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Medical Limitations and Exclusions

PEHP strictly enforces the limits on payments and coverage available to you. This is done according to the terms, conditions, limitations, and exclusions contained in this document, the Benefit Summary Grids and the PEHP Master Policy.

You should not expect that any services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment will be covered or otherwise provided or paid for by PEHP in excess of the kinds and amounts specified in the PEHP Master Policy and this Benefits Summary. You are always free to personally obtain and pay for services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment outside of the coverage provided to you through PEHP.

Unless otherwise noted in the Benefit Summary Grids, the following general limitations and exclusions apply. **This is not a complete list of limitations and exclusions that apply to your coverage. Please see the PEHP Master Policy for a complete list of limitations and exclusions.**

Limitations

The following services are limited under your plan:

1. All eligible services performed by eligible providers are considered for payment up to PEHP's maximum allowable fee.
2. When medically appropriate, PEHP Case Managers may approve the transfer of patients from an inpatient hospital setting to a transitional care unit or skilled nursing facility.
3. All services, including complications, for the following procedures will be covered at 50% of PEHP's allowable fee:
   a. Breast reduction;
   b. Eligible testing and treatment for infertility;
   c. Blepharoplasty or other eyelid surgery;
   d. Spinal cord stimulators;
   e. All facility claims related to a hospital stay when the member is discharged against medical advice.
4. Payment for the following benefits will be limited to the dollar amount or visit limit shown below for the lifetime of your coverage with PEHP and will apply when a member terminates and reinstates coverage:
   a. Non-surgical treatment of TMJ/TMD – $1,000;
   b. Speech therapy – 60 visits.
5. Emergency care for life-threatening injury or illness caused by attempted suicide or anorexia/bulimia is covered as a medical benefit. Once the patient's health is stabilized, further benefits will be payable at the inpatient mental health benefit level.
6. Organ or tissue donor charges for eligible transplants are not covered, except when the recipient is an eligible member covered under a PEHP plan. Laboratory typing/testing for organ transplants is eligible only when the recipient is an eligible member covered under a PEHP plan.
7. Multiple eligible surgical procedures performed during the same operative session are payable at 100% of the maximum allowable fee for the primary procedure and 50% for all additional procedures.
8. Services that are dental in origin, including care and treatment of teeth and gums, orthodontia, periodontia, endodontia or prosthodontia are not covered, unless services are related to a dental accident and your plan includes coverage for dental accidents. If coverage for a dental accident is allowed by your plan, the dental injury must occur while coverage for dental accident benefits are in place and treatment must be completed within 24 months of the dental accident. Only treatment to sound, natural teeth will be covered. Sound, natural teeth are teeth that are whole or properly restored, are without impairment or periodontal disease and are not in need of treatment for reasons other than the dental injury.
9. Physical and occupational therapy requires pre-authorization after 12 visits per plan year combined.
10. Only one medical, psychiatric, chiropractic, physical therapy, or osteopathic visit per day for the same diagnosis when billed by providers of the same specialty for any one member is allowable.
11. Speech therapy by a qualified speech therapist requires Pre-authorization. Eligible Benefits are payable up to plan limits. Eligible Benefits are limited to 60 visits per Member per lifetime.

    Therapy or evaluation provided by speech therapists for dysphagia (difficulty in swallowing) is payable separate from the speech therapy limit as a medical visit.
12. Predictive genetic counseling except in conjunction with the Affordable Care Act (Preventive Services under Section 6.14) or as Medically Necessary, as determined by PEHP.
13. Inpatient provider visits will be payable only in

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Medical Limitations and Exclusions

conjunction with authorized inpatient days.

14. Benefits for ground ambulance are payable only for medical emergencies and only to the nearest facility where proper care is available. Benefits for air ambulance are payable only for life-threatening emergencies when you could not be safely transported by ground ambulance and only to the nearest facility where proper medical care is available. If the emergency is not considered to be life-threatening by PEHP, air ambulance charges will be paid up to the lowest ground ambulance rate for non-contracted ambulance services in Utah.
15. Skilled nursing visits may be approved up to a limit of 60 visits per plan year.
16. Hospice services may be approved for up to 6 months in a 3 year period.
17. Not all Durable Medical Equipment (DME) will be covered at plan benefits. Please refer to Appendix A of the PEHP Master Policy for a list of covered and non-covered equipment, as well as pre-authorization requirements. Any equipment not listed in Appendix A of the PEHP Master Policy requires pre-authorization.
18. Machine rental or purchase for the treatment of sleep disorders is payable at plan benefits, up to $2,500 in a five-year period, including all related equipment and supplies.
19. Artificial prosthetics, such as eyes or limbs, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Pre-authorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.
20. Wheelchairs require Pre-authorization through Medical Case Management. The maximum power wheelchair benefit available is one in any five-year period.
21. Reimbursement for knee braces is limited to one per knee in a three-year period.
22. Sleep studies for sleep disorders are payable up to a maximum benefit of $2,000 in a three-year period.
23. Amounts paid for the following services will not apply to your out-of-pocket maximum*:
    a. Inpatient or outpatient mental health or substance abuse treatment for plans that do not have mental health parity or separate mental health substance abuse yearly out-of-pocket maximums;
    b. Temporomandibular Joint (TMJ/TMD/myofacial pain) treatment;
    c. Sleep apnea testing or equipment;
    d. Infertility testing, surgery, or equipment;
    e. Surgeries or procedures payable at 50%;
    f. Adoption;
    g. Penalties for failing to obtain Pre-authorization or to complete Pre-notification;
    h. Prescription drugs;
    i. Supplies obtained through the pharmacy card;
    j. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
    k. Charges in excess of PEHP's maximum allowable fee or contract limitations;
    l. Charges applied to your Deductible(s);
    m. Charges for hospital services when the patient was discharged against medical advice (AMA); or
    n. Specialty drugs obtained through a provider's office or outpatient facility will have a separate out-of-pocket maximum and will not apply to the medical out-of-pocket maximum.

* Some of these benefits may apply to the out-of-pocket maximum on STAR plans.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Medical Limitations and Exclusions

Exclusions

The following services are not covered under your plan:

1. All services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures or equipment related to non-covered services are not covered. When a non-covered service is performed as part of the same operation or process as a covered service, then only eligible charges relating to the covered service will be eligible for benefits.
2. Medical services, procedures, supplies or drugs used to treat secondary conditions or complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such complications include, but are not limited to:
    a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof;
    b. Complications as a result of a cosmetic surgery or procedure, except in cases of reconstructive surgery:
        1. When the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved party; or
        2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect; or
    c. Complications relating to services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than its FDA-Approved purpose.
3. Any care, treatment or procedure performed primarily for cosmetic purposes is not covered. Services are considered cosmetic when they are intended to improve appearance or correct a deformity without restoring physical bodily function. Cosmetic services that are not covered include, but are not limited to:
    a. Breast reconstructive surgery except as allowed under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). (See the WHCRA notice in this Benefits Summary for further information and limitations);
    b. Any reconstructive surgery, except those made necessary by an accidental injury occurring in the preceding 5 years;
    c. Rhinoplasty, except as a result of an accidental injury occurring in the preceding 5 years;
    d. Lipectomy, abdominoplasty, repair of diastasis recti and panniculectomy;
    e. Hair transplants or other services to treat hair loss.
4. Treatment programs for enuresis or encopresis for Members age 18 and over.
5. Services or items primarily for convenience or other non-therapeutic purposes, such as: guest trays, personal hygiene items, home health aide and home nursing.
6. Services provided in a nursing home, rest home or a transitional living facility, community reintegration program, or vocational rehabilitation services to re-train self-care or activities of daily living (ADLs), including occupational therapy for activities of daily living (ADLs), academic learning, vocational or life skills or developmental delays.
7. Recreational therapy in any setting.
8. Biological serum, blood and blood plasma are not covered through the pharmacy card. Charges related to storing blood for future use.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
10. Custodial care and/or maintenance therapy.
11. Take home medications.
12. Obesity surgery, such as gastric bypass, lap-band surgery, etc., including any present and future complications.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Medical Limitations and Exclusions

13. Assisted reproductive technologies: invitro fertilization (IVF); gamete intra-fallopian tube transfer (GIFT); embryo transfer (ET); zygote intra fallopian transfer (ZIFT); pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
14. Surgical treatment for correction of refractive errors.
15. Reversal of sterilization.
16. All services related to gender dysphoria or gender identity disorder.
17. Sperm banking system, storage, treatment or other such services.
18. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by PEHP.
19. Any surgery solely for snoring.
20. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
21. Treatment for sexual dysfunction.
22. Charges for physical examinations performed in connection with hearing aids.
23. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.
24. Epidemiological counseling and screening.
25. Acupuncture treatment.
26. Hypnotherapy and biofeedback services.
27. Testing and treatment therapies for developmental delay or child development programs.
28. Cardiac rehabilitation, Phases 3 and 4.
29. Pulmonary rehabilitation, Phases 3.
30. Fitness programs.
31. Childbirth education classes.
32. The practice of using numerous procedure codes to identify procedures that normally are covered by a single code, known as "unbundling".
33. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
34. Hospital leave of absence charges.
35. Service for milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
36. Residential treatment programs.
37. Ambulance services for the convenience of the patient or family.
38. Private duty nursing, home health aide, custodial care and respite care.
39. Travel or transportation expenses, or escort services to provider's offices or elsewhere.
40. The following adoption related expenses will not be covered:
    a. Expenses incurred from the adoption of nieces, nephews, brothers, sisters, grandchildren, cousins or stepchildren;
    b. Transportation, travel expenses or accommodations, passport fees, photos, postage, etc.;
    c. Living expenses, food and/or counseling for the birth mother.
41. Equipment purchased from non-licensed providers.
42. Used Durable Medical Equipment.
43. Charges for all services received as a result of an industrial claim (on-the job) injury or illness, any portion of which, is payable under Worker's Compensation or employer's liability laws.
44. Charges in conjunction with a pre-existing condition during the pre-existing condition waiting period.
45. Charges that you are not, in absence of coverage, legally obligated to pay.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Medical Limitations and Exclusions

46. Charges for medical care rendered by an immediate family member are not covered. Immediate family members are spouses, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, stepparents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces and nephews, domestic partners, and adult designees.
47. Overutilization of medical benefits as determined by PEHP.
48. Charges that are not medically necessary to treat the condition, as determined by PEHP, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury.
49. PEHP will not pay for charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which you are, or could be covered.
50. Charges for services as a result of an auto-related injury covered under No-fault insurance or that would have been covered if coverage were in effect as required by law.
51. Any service or supply not specifically identified as a benefit.
52. Services incurred in connection with injury or illness arising from the commission of:
    a. a felony;
    b. an assault, riot or breach of peace;
    c. a Class A misdemeanor;
    d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. other illegal acts of violence.
53. Claims submitted past the timely filing limit as described in the applicable benefit summary.
54. Mastectomy for gynecomastia.
55. TENS units.
56. Neuromuscular stimulators.
57. H-wave electronic devices.
58. Sympathetic therapy stimulators.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Prescription Drug Coverage

This section contains important information about using your prescription drug benefits, including certain requirements and limitations that you should know. This summary should be used in conjunction with the Benefits Summary Grid and the PEHP Master Policy. Please refer to the PEHP Master Policy for a full and complete description of your benefits.

Prescription and Injectable Drug Benefits

You will receive a member identification (ID) card upon enrollment. The ID card will only list the subscriber's name, but will provide coverage for each enrolled family member. You only need to present your ID card or provide your ID number to a participating pharmacy along with an eligible prescription and any applicable copayment to receive your prescription medication. Prescription drugs purchased through PEHP's pharmacy program are exempt from any Pre-existing waiting period.

The PEHP pharmacy benefit provides pharmacy and injectable coverage through our pharmacy network, administered by PEHP's Pharmacy Benefits Manager (PBM), Express Scripts. PEHP offers coverage of blood pressure medications, birth control pills, insulin, diabetic supplies and almost all other prescription drugs through our Preferred Drug List.

The Preferred Drug List is a listing of prescription medications that PEHP has chosen to be available at a lower copayment. The medications on the Preferred Drug List provide the best overall value based on quality, safety, effectiveness, and cost. The Preferred Drug List is modified periodically based on recommendations from PEHP's Pharmacy and Therapeutics Committee.

Your Pharmacy and Specialty benefit is categorized by the following tiers:

- **Tier 1:** Preferred generic drugs that are available at your lowest copayment.
- **Tier 2:** Preferred brand name drugs that are available at the middle copayment.
- **Tier 3:** Non-preferred medications that are available at the highest copayment.
- **Tier A:** Preferred Specialty oral and injectable medications available at the lowest specialty Copayment listed in your Benefit Summary.
- **Tier B:** Non-preferred Specialty medications available at the highest specialty Copayment listed in your Benefit Summary.

Visit www.pehp.org or call PEHP for the tier placement of your medication or Preferred Drug List recommendations.

Participating Pharmacies

To get the most from your prescription drug benefit, you must use a participating pharmacy and always present your ID card when filling a prescription. Most large chains and local pharmacies participate in the Express Scripts network. Visit www.pehp.org for more information on participating pharmacies. If you are traveling outside the service area, you may contact our PBM Customer Service Department for the location of the nearest contracted pharmacy in the United States.

If you must fill a prescription without your ID card in an urgent or emergency situation, you may pay the full amount of the prescription and mail a reimbursement form along with a receipt to Express Scripts for reimbursement. Find reimbursement forms at www.pehp.org. Urgent and emergent medications obtained outside the United States will be covered when the drug or class of medication is covered under the PEHP Pharmacy or injectable benefit. PEHP will determine the urgent or emergent status of each claim submitted for reimbursement. All claims are subject to pre-authorization, step therapy, and quantity levels. PEHP will reimburse up to our maximum allowable fee, minus the required copayment.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Prescription Drug Coverage

Specialty and Injectable Drugs

Specialty and injectable drugs are typically bio-engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

Our specialty pharmacy, Accredo, will coordinate with you or your physician to provide delivery to either your home or your provider's office. Sometimes Specialty Drugs may be available through both our specialty pharmacy and through your provider's office or facility. In these cases PEHP will offer your specialty medication for a lower copayment and/or a lower maximum out-of-pocket cost through our specialty pharmacy. Pre-authorization may be required, and you may also have a separate out-of-pocket maximum of $3,600 per member per year for medications you receive through a provider's office or facility.

Copayments through Accredo will not apply to the $3,600 specialty out-of-pocket maximum on the Medical plan. Visit www.pehp.org or call PEHP for a complete list of the medications required to be dispensed through our designated specialty pharmacy or those that are subject to a specialty benefit copayment.

Generic Substitution

You are required to pay the difference between a generic medication and a brand name drug plus a generic copayment when the brand name drug is dispensed instead of a substitutable generic medication. If your benefit plan has a deductible, the cost difference between a brand-name drug and a generic equivalent does not apply to meeting your deductible. The cost difference will not apply to meeting your out-of-pocket maximum.

Mail-Order Prescriptions

You can purchase a 90-day supply of a maintenance medication at Express Scripts mail-order facility. Maintenance medications are the only drugs available through our mail-order program. Maintenance drugs are prescribed to treat chronic conditions as defined by the FDA or PEHP.

Examples of maintenance medications available through mail-order include:

a. Diabetes medications
b. Anticonvulsants
c. Birth control pills
d. Blood pressure drugs
e. Asthma medications
f. Antidepressants.

Examples of medications not available through mail-order include:

a. Antibiotics
b. Anti-anxiety
c. Anti-migraine
d. Injectables
e. Pain medications
f. Muscle relaxants.

To use mail-order, you should ensure that your medication is eligible for mail-order and all pre-authorization requirements have been met before sending in a prescription. Obtain a 90-day prescription from your physician, complete a mail-order form and send the order along with payment to the address listed on the order form. PEHP's mail-order facility is unable to fill prescriptions written for less than 90-day supplies.

You should always have a two-week supply of medication on hand to allow time for delivery.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Prescription Drug Coverage

Pharmacy Limitations and Exclusions

PEHP strictly enforces the limits on payments and coverage available to you. This is done according to the terms, conditions, limitations, and exclusions contained in this document, the Benefits Summary grid and the PEHP Master Policy.

You should not expect that any services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment will be covered or otherwise provided or paid for by PEHP in excess of the kinds and amounts specified in the PEHP Master Policy and the Benefits Summary. You are always free to personally obtain and pay for services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment outside of the coverage provided to you through PEHP.

Unless otherwise noted in this Benefits Summary, the following general limitations and exclusions apply to your pharmacy and drug benefits. This is not a complete list of limitations and exclusions that apply to your coverage. See the PEHP Master Policy for a complete list of limitations and exclusions.

1. Drug quantities, dosage levels, and length of therapy may be limited to the recommendations of the drug manufacturer, FDA , clinical guidelines, or PEHP's Pharmacy and Therapeutics Committee.
2. Cash paid and COB claims will be subject to PEHP's pre-authorization, step therapy, benefit coverage, and quantity levels. PEHP will reimburse up to the PBM contracted rate and PEHP's benefit rules.
3. PEHP may limit the availability and filling of any prescription for a controlled substance or other prescription drug that is susceptible to misuse. The following are some, but not all, of the tools the Pharmacy or Case Management Department may use to address any misuse of drugs:
    a. Require you to fill prescriptions at a specified pharmacy.
    b. Require you to obtain drugs only in medically necessary dosages and supplies.
    c. Require you to obtain prescriptions only from a specified provider.
    d. Require completion of a drug treatment program.
    g. Deny medications or quantities in excess of what is medically necessary.
4. Retail and mail order prescriptions are not refillable until 75% of the total prescription supply is used.
5. Vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements are not covered. Prenatal vitamins and folic acid will be covered if required for pregnancy.
6. Medications needed for participation in any drug research or medication study are not covered.
7. New medications released by the FDA will not be covered until they are reviewed for efficacy, safety, and cost-effectiveness by PEHP's Pharmacy and Therapeutics Committee.
8. Over-the-counter medications and products are not covered, unless they are listed in PEHP's Preferred Drug List.
9. Medications dispensed from a non-contracted institution or methadone clinic when you do not use your pharmacy card are not covered.
10. Compound drugs and powders are not covered.
11. Replacement of lost, stolen or damaged medications is not covered.
12. Skin patches for motion sickness are not covered.
13. Oral and nasal antihistamines for allergies are not covered.
14. Medications obtained outside the United States that are not for urgent or emergent conditions are not covered.
15. Drugs used for sexual impotence or enhancement are not covered.

This applies only to The STAR Plan and Traditional plan. See Pages 50-61 for information that applies to Utah Basic Plus.

Wellness and Value-Added Benefits

Healthy Utah

Subscribers and their spouses are eligible to attend one PEHP Healthy Utah testing session each plan year free of charge. PEHP Healthy Utah is offered at the discretion of the Employer.

FOR MORE INFORMATION

Healthy Utah

801-366-7300 or 855-366-7300

PEHP WeeCare

PEHP WeeCare is our pregnancy case management service. It's a prenatal risk reduction program that offers education and consultation to expectant mothers.

Participate in PEHP WeeCare and you may qualify to get free pre-natal vitamins, free books, and cash incentives.

While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

FOR MORE INFORMATION

PEHP WeeCare
P.O. Box 3503
Salt Lake City, Utah 84110-3503
801-366-7400 | 855-366-7400

PEHP Plus

The money-saving program PEHPplus helps promote good health and save you money. It provides savings on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. Learn more at www.pehp.org/plus.

PEHP Waist Aweigh

PEHP Waist Aweigh is a weight management program offered at no extra cost to eligible members and spouses enrolled in a PEHP medical plan. If you have a Body Mass Index (BMI) of 30 or higher, you may qualify. PEHP Waist Aweigh is offered at the discretion of the Employer.

For more information about PEHP Waist Aweigh and to apply, go to www.pehp.org and click "Wellness and Disease Management."

HOW TO SIGN UP

Fill out an enrollment form available at www.pehp.org or call 801-366-7300 or 855-366-7300.

FOR MORE INFORMATION

PEHP Waist Aweigh

801-366-7300 | 855-366-7300

- **» E-mail: waistaweigh@pehp.org**
- **» Web: www.pehp.org**

If you are unable to meet the medical standards to qualify for the program because it is medically unadvisable or unreasonably difficult due to a medical condition, upon written notification, PEHP will provide you with a reasonable alternative standard to qualify for the program. Members who claim the PEHP Waist Aweigh $200 reward are ineligible for the Healthy Utah rebate for BMI reduction. The total amount of rewards cannot be more than 20% of the cost of employee-only coverage under the plan. PEHP Waist Aweigh rebates may be taxable. Please consult with your tax advisor for tax advice concerning your benefits.

Life Assistance Counseling

PEHP pays for members to use Blomquist Hale Consulting for distressing life problems such as: marital struggles, financial difficulties, drug and alcohol issues, stress, anxiety, depression, despair, death in family, issues with children, and more. Blomquist Hale Life Assistance Counseling is a confidential counseling and wellness service provided to members and covered at 100% by PEHP.

FOR MORE INFORMATION

Blomquist Hale, 800-926-9619

- **» Web: www.blomquisthale.com**

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Using Your Medical Benefits

This document is a summary only. It is not a contract. The PEHP Master Policy is the contract between you and your Dependents and PEHP. Refer to the PEHP Master Policy for a full and complete description of your benefits.

Member Identification Card

You will receive up to two identification cards when you first enroll with PEHP. The identification cards are used for prescription drug, medical, dental, and out of state benefits (see page 39 or 51 for Coverage Outside of Utah). You and your dependents will be asked to present this card when you fill prescriptions and when you receive medical care. The information on the card allows your provider to bill both you and PEHP correctly. New cards will not be issued every year, but only when the information on the card changes. If you lose your card or need additional cards for dependents, you may request them by calling PEHP.

Contracted Providers

Providers who are Contracted with PEHP have agreed to accept a maximum allowable fee for each service performed when seeing PEHP Members. You are responsible to pay only the Deductible and Coinsurance for any eligible amount listed in the benefits grid. The Contracted provider will accept the amount PEHP paid, along with your Deductible and Coinsurance amount, as payment in full for the claim.

Provider Directories

Refer to the PEHP Provider Directories at www.pehp.org for the most current listing of providers and facilities contracted with PEHP. You may request a printed copy of the Provider Directories by calling PEHP.

Non-Contracted Providers

Providers who are not contracted with your network have not agreed to accept PEHP's Allowed Amount. This means that you will be responsible to pay the Deductible and Coinsurance amount listed in the benefits grid, as well as the difference between the non-contracted providers' billed charge and the PEHP allowable amount.

Pre-notification and Pre-authorization

Certain medical services require pre-notification or pre-authorization by PEHP before being eligible for payment. While many contracted and non-contracted providers will generally pre-authorize or pre-notify on your behalf, it is your responsibility to ensure that PEHP has received notice and/or granted approval for any service requiring pre-notification or pre-authorization prior to the services being received. If you do not pre-authorize or pre-notify services that require such approval, benefits may be reduced or denied by PEHP.

Failure to pre-notify inpatient hospitalization for elective admissions will result in a reduction of benefits of $200 per day for each day not pre-notified. Failure to pre-notify non-elective admissions will result in a reduction of benefits of $200 per day for each day after the third day that is not pre-notified. No benefits are payable for Mental Health admissions without pre-authorization.

The following services require pre-notification by calling PEHP Customer Service:

- All skilled nursing facility admissions
- All inpatient hospital rehabilitation admissions
- All inpatient hospitalizations
- All inpatient mental health facility admissions.

The following services require verbal pre-authorization by calling PEHP Customer Service:

- Any inpatient maternity stay that exceeds 48 hours following a vaginal delivery or 96 hours following delivery by Cesarean section.

The following is a list of the most common services requiring written pre-authorization. It is not all inclusive. Call PEHP if you have any questions regarding pre-authorization:

- Surgery that may be partially or wholly Cosmetic
- Coronary CT angiography
- Organ or tissue transplants
- Surgery performed in conjunction with obesity Surgery
- Implantation of artificial Devices
- New and Unproven technologies
- Cochlear implants

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Using Your Medical Benefits

- Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days
- Botox injections
- Maxillary/Mandibular bone or Calcitite augmentation Surgery
- All out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life-threatening
- Wound care, except for the diagnosis of burns
- Home health and Hospice Care
- Hyperbaric oxygen treatments
- Intrathecal pumps
- Spinal cord stimulators
- Surgical Procedures utilizing robotic assistance
- Implantable medications, excluding contraception
- Certain prescription and Specialty Drugs
- Continuous glucose monitoring Devices and supplies
- Jaw surgery
- Dialysis when using non-Contracted Providers
- Human pasteurized milk
- Stereotactic radiosurgery
- Magnetoencephalography (MEG)/ magnetic source imaging
- Breast reconstruction surgery
- Virtual colonoscopy
- Transanal endoscopic microsurgery
- Endovenous ablation therapy (Radiofrequency or laser)
- Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation).

Coverage Outside of Utah

PEHP has made an arrangement with the MultiPlan network of providers and facilities to help reduce your out-of pocket costs when you receive care outside of Utah. MultiPlan providers are considered contracted providers for the purpose of claims payment. The MultiPlan network is only available to the following PEHP Members: 1) Members who are living outside the State of Utah (Members who are living outside the State of Utah must notify PEHP of their out-of-state address prior to receiving Coverage); 2) Members traveling outside the State of Utah who are in need of urgent or life-threatening services while traveling (Coverage is excluded for services outside the State of Utah when a Member is traveling for the purpose of seeking medical care or treatment.); or 3) Members that require medical services that are not available in Utah and that have been Pre-authorized by PEHP. Locate a contracted provider outside of Utah at www.multiplan.com, or by calling 800-922-4362. You must show your PEHP Medical Identification card at the time of service, otherwise, PEHP can't guarantee discounts or in-network benefits.

The National Access Program is not available to Members enrolled in Conversion or PEHP Basic Care.

Urgent Care Condition

PEHP considers an urgent condition as an illness or injury that is not life-threatening, but requires medical attention within 24 hours.

Services to treat an urgent condition by a non-contracted provider in Utah will be allowed up to the Maximum Allowable fee and paid by PEHP at the amount specified for Non-Contracted Providers in the Members applicable benefit grid.

Services to treat an urgent condition by a non-contracted provider outside of Utah will be allowed up to the Allowed Amount by State average as determined by the National Access Program, or negotiated fees, and paid by PEHP at the amount specified for Non-Contracted Providers in the Members applicable benefit grid.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Medical Limitations and Exclusions

Life-Threatening Emergencies in Utah

Medical services to treat a Life-threatening condition from a non-Contracted Provider in Utah will be allowed up to the Allowed Amount and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary. In the case of in-patient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with PEHP's Medical Case Management.

Life-Threatening Emergencies Outside of Utah

Medical services to treat a Life-threatening condition from a non-Contracted Provider outside of Utah will be allowed by PEHP at the Allowed Amount by State average as determined by the National Access program, or negotiated fees and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary. In the case of in-patient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with PEHP's Medical Case Management.

Emergency Transportation

Ambulance services are payable only in the case of medical emergencies and only for transportation to the nearest facility capable of treating your condition, or when you cannot safely be transported by other means. See the Limitations and Exclusions section of this Benefit Summary for more information.

Medical Case Management

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager will work with the Member, the Member's family, Providers, outside consultants and others to coordinate a comprehensive, medically appropriate treatment plan.

Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines.

PEHP, at its own discretion, may require a Member to obtain Pre-authorization for any and all benefits in coordination with Medical Case Management, if PEHP has determined such action is warranted by the Member's claims history.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Medical Limitations and Exclusions

Limitations and Exclusions

The following services are not covered or are limited under your plan:

1. All eligible services performed by eligible providers are considered for payment up to PEHP's maximum allowable fee.
2. All services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures or equipment related to non-covered services are not covered. When a non-covered service is performed as part of the same operation or process as a covered service, the eligible charges will be denied.
3. Medical services, procedures, supplies or drugs used to treat secondary conditions or complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such complications include, but are not limited to:
   a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof;

   b. Complications as a result of a cosmetic surgery or procedure, except in cases of reconstructive surgery:

      1. When the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved party; or

      2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect; or

   c. Complications relating to services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than its FDA-Approved purpose.
4. Any care, treatment or procedure performed primarily for cosmetic purposes is not covered. Services are considered cosmetic when they are intended to improve appearance or correct a deformity without restoring physical bodily function. Cosmetic services that are not covered include, but are not limited to:
   a. Breast reconstructive surgery except as allowed under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). (See the WHCRA notice in this Benefits Summary for further information and limitations);
   b. Any reconstructive surgery, except those made necessary by an accidental injury occurring in the preceding 5 years;
   c. Rhinoplasty, except as a result of an accidental injury occurring in the preceding 5 years;
   d. Lipectomy, abdominoplasty, repair of diastasis recti and panniculectomy;
   e. Hair transplants or other services to treat hair loss.
5. When medically appropriate, PEHP Case Managers may approve the transfer of patients from an inpatient hospital setting to a transitional care unit or skilled nursing facility.
6. The following services are not covered:
   a. Breast reduction;
   b. Testing and treatment for infertility;
   c. Blepharoplasty or other eyelid surgery;
   d. Sclerotherapy;
   e. Microphlebectomy (Stab phlebectomy);
   f. All facility claims related to a hospital stay when the member is discharged against medical advice.
7. Sleep disorder testing is not covered.
8. Emergency care for Life-threatening injury or illness caused by attempted suicide or anorexia/bulimia is covered as a medical benefit. Once the patient's health is stabilized, further benefits will be payable at the inpatient mental health benefit level.
9. Treatment programs for enuresis or encopresis are not covered.
10. Services or items primarily for convenience or other non-therapeutic purposes, such as: guest trays, personal hygiene items, home health aide and home nursing, are not covered.
11. Services provided in a nursing home, rest home or a transitional living facility, community reintegration program, or vocational rehabilitation services to re-train self-care or activities of daily living (ADLs), including occupational therapy for activities of daily living (ADLs), academic learning, vocational or life skills or developmental delays, are not covered.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Medical Limitations and Exclusions

12. Recreational therapy in any setting is not covered.
13. Biological serum, blood and blood plasma are not covered through the pharmacy card. Charges related to storing blood for future use are not covered.
14. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible, are not covered.
15. Outpatient nutritional analysis or counseling is not covered, except in conjunction with anorexia/bulimia, diabetes education, and Affordable Care Act Preventive Services.
16. Custodial care and/or maintenance therapy is not covered.
17. Take home medications are not covered.
18. Multiple eligible surgical procedures performed during the same operative session are payable at 100% of the maximum allowable fee for the primary procedure and 50% for all additional procedures.
19. Obesity surgery, such as gastric bypass, lap-band surgery, etc., including any present and future complications, is not covered.
20. All services related to infertility are not covered.
21. Surgical treatment for correction of refractive errors is not covered.
22. Reversal of sterilization is not covered.
23. All services related to gender dysphoria or gender identity disorder are not covered.
24. Services that are dental in origin, including care and treatment of teeth and gums, orthodontia, periodontia, endodontia or prosthodontia are not covered.
25. Sperm banking system, storage, treatment or other such services are not covered.
26. Artificial prosthetic limbs are not covered. Artificial prosthetic eyes, when made necessary by loss from an injury or illness, must be pre-authorized. If approved, the maximum prosthetic benefit is once in five years, per site.
27. Laser assisted uvulopalotoplasty (LAUP) or any other surgery solely for snoring is not covered.
28. Abortions, except as in accordance with Utah State Law, are not covered.
29. Treatment for sexual dysfunction is not covered.
30. Physical, occupational, and speech therapy visits are only payable up to combined plan limits. Please refer to the benefit grid for limit information.
31. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis, when billed by providers of the same specialty, is eligible for payment.
32. Speech therapy will only be payable to restore speech loss or correct an impairment due to surgery for a congenital defect, an injury or illness, for children with Cerebral Palsy, and for permanent hearing loss due to otitis media. Therapy must be performed by a qualified speech therapist. Please see the PEHP Master Policy for more information.
33. Charges for physical examinations performed in connection with hearing aids are not covered.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Medical Limitations and Exclusions

34. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.
35. Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services is not covered.
36. Acupuncture treatment is not covered.
37. Hypnotherapy and biofeedback services are not covered.
38. Testing and treatment therapies for developmental delay or child development programs are not covered.
39. Cardiac rehabilitation, Phases 3 and 4 are not covered.
40. Pulmonary rehabilitation, Phase 3 is not covered.
41. Fitness programs are not covered.
42. Childbirth education classes are not covered.
43. The practice of using numerous procedure codes to identify procedures that normally are covered by a single code, known as "unbundling", is not covered.
44. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations are not covered.
45. Inpatient provider visits will be payable only in conjunction with authorized inpatient days.
46. Hospital leave of absence charges are not covered.
47. Service for milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances are not covered.
48. Residential treatment programs are not covered.
49. Benefits for ground ambulance are payable only for medical emergencies and only to the nearest facility where proper care is available. Benefits for air ambulance are payable only for Life-threatening emergencies when you could not be safely transported by ground ambulance and only to the nearest facility where proper medical care is available. If the Emergency is not considered to be Life-threatening by PEHP, air ambulance charges will be paid up to the lowest ground ambulance rate for non-Contracted ambulance services in Utah.
50. Ambulance services for the convenience of the patient or family are not covered.
51. Skilled nursing visits may be approved up to a limit of 30 visits per plan year.
52. Hospice services may be approved for up to 6 months in a 3 year period.
53. Private duty nursing, home health aide, custodial care and respite care is not covered.
54. Travel or transportation expenses, or escort services to provider's offices or elsewhere are not covered.
55. Not all Durable Medical Equipment (DME) will be covered at plan benefits. Please refer to Appendix A of the PEHP Master Policy for a list of covered and non-covered equipment, as well as Pre-authorization requirements. Any equipment not listed in Appendix A of the PEHP Master Policy requires Pre-authorization and may not be covered.
56. Machine rental or purchase for the treatment of sleep disorders, including all related equipment and supplies, is not covered.
57. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by PEHP.
58. Wheelchairs require Pre-authorization through Medical Case Management and are limited to one in any five-year period.
59. Reimbursement for knee braces is limited to one in a three-year period.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Medical Limitations and Exclusions

60. New or used equipment purchased from non-licensed providers is not covered.
61. Used Durable Medical Equipment is not covered.
62. Charges for all services received as a result of an industrial claim (on-the job) injury or illness, any portion of which, is payable under Worker's Compensation or employer's liability laws are not covered.
63. Charges in conjunction with a pre-existing condition during the pre-exisiting condition exclusion period are not covered.
64. Charges that you are not, in absence of coverage, legally obligated to pay are not covered.
65. Charges for medical care rendered by an immediate family member are not covered. Immediate family members are spouses, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, step-parents, step-children, grandparents, grandchildren, uncles, aunts, nieces and nephews.
66. Charges that are not Medically Necessary to treat the condition, as determined by PEHP, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury are not covered.
67. Overutilization of medical benefits as determined by PEHP is not covered.
68. Charges for services as a result of an auto-related injury covered under No-fault insurance or that would have been covered if coverage were in effect as required by law, are not covered.
69. Any service or supply not specifically identified as a benefit is not covered.
70. No services are covered when incurred in connection with injury or illness arising from the commission of:
    a. a felony;
    b. an assault, riot or breach of peace;
    c. a Class A misdemeanor;
    d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. other illegal acts of violence.
71. Claims submitted past the timely filing limit as described in the applicable benefit summary are not covered.
72. Amounts paid for the following services will not apply to your out-of-pocket maximum:
    a. Penalties for failing to obtain Pre-authorization or to complete Pre-notification;
    b. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
    c. Charges in excess of PEHP's maximum allowable fee or contract limitations.
73. Mastectomy for gynecomastia is not covered.
74. The following Durable Medical Equipment is not covered:
    a. TENS units;
    b. Neuromuscular stimulator;
    c. H-Wave electronic devices;
    d. Sympathetic therapy stimulators.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Subrogation

Subrogation

You agree to seek recovery from any person who may be obligated to pay damages arising from occurrences or conditions caused by the person for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of your efforts to recover from those person(s). If you do not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on your behalf.

In the event that Eligible Benefits are furnished to you for bodily injury or illness, you shall reimburse PEHP with respect to your right (to the extent of the value of the benefits paid) to any claim for bodily injury or illness, regardless of whether you have been "made whole" or have been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for your claims for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to any attorney fees or costs you choose to incur in securing the amount of the claim.

ACCEPTANCE OF BENEFITS AND NOTIFICATION

Acceptance of the benefits hereunder shall constitute acceptance of PEHP's right to Subrogation rights as explained above. You are required to do the following:

- Promptly notify PEHP of all possible subrogation/restitution situations;
- Help PEHP or PEHP's designated agent to assert its subrogation/restitution interest;
- Not settle any dispute with a third party without protecting PEHP's subrogation/restitution interest; and
- Sign any papers required to enable PEHP to assert its subrogation/restitution interest.

RECOUPMENT OF BENEFIT PAYMENT

In the event you impair PEHP's Subrogation rights under this contract through failure to notify PEHP of potential liability, settling a claim with a responsible party without PEHP's involvement, or otherwise, PEHP reserves the right to recover from you the value of all benefits paid by PEHP on your behalf resulting from the party's acts or omissions. No judgment against any party will be conclusive between you and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Prescription Drug Coverage

This section contains important information about using your prescription drug benefits, including certain requirements and limitations that you should know. This summary should be used in conjunction with the Benefits Summary Grid and the PEHP Master Policy. Please refer to the PEHP Master Policy for a full and complete description of your benefits.

Prescription and Injectable Drug Benefits

You will receive a member identification (ID) card upon enrollment. The ID card will only list the subscriber's name, but will provide coverage for each enrolled family member. You only need to present your ID card or provide your ID number to a participating pharmacy along with an eligible prescription and any applicable copayment to receive your prescription medication. Prescription drugs purchased through PEHP's pharmacy program are exempt from any Pre-existing waiting period.

The PEHP pharmacy benefit provides pharmacy and injectable coverage through our pharmacy network, administered by PEHP's Pharmacy Benefits Manager (PBM), Express Scripts. PEHP offers coverage of blood pressure medications, birth control pills, insulin, diabetic supplies and many other prescription drugs.

The PEHP Pharmacy and Specialty Drug benefit is categorized by the following tiers:

- **Tier 1:** Preferred generic and brand name drugs.
  - **Specialty injectable drugs:** Injectable drugs obtained through Accredo.
  - **Specialty oral drugs:** Oral drugs obtained through Accredo.

Contact PEHP Customer Service to learn more about the cost of your medication.

Participating Pharmacies

To get the most from your prescription drug benefit, you must use a participating pharmacy and always present your ID card when filling a prescription. Most large chains and local pharmacies participate in the Express Scripts network. Visit www.pehp.org for more information on participating pharmacies. If you are traveling outside the service area, you may contact our PBM Customer Service Department for the location of the nearest Contracted pharmacy in the United States.

If you must fill a prescription without your ID card in an Urgent or Emergency situation, you may pay the full amount of the prescription and mail a reimbursement form along with a receipt to Express Scripts for reimbursement. Find reimbursement forms at www.pehp.org. All claims are subject to Pre-authorization, step therapy, and quantity levels. PEHP will reimburse up to our maximum allowable fee, minus the required Coinsurance.

Specialty and Injectable Drugs

Specialty oral and injectable drugs are typically bioengineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

Our specialty pharmacy, Accredo, will coordinate with you or your physician to provide delivery to either your home or your provider's office. Pre-authorization may be required.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Prescription Drug Coverage

Pharmacy Limitations and Exclusions

PEHP strictly enforces the limits on payments and coverage available to you. This is done according to the terms, conditions, limitations, and exclusions contained in this document, the Benefit Summary Grid and the PEHP Master Policy.

You should not expect that any services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment will be covered or otherwise provided or paid for by PEHP in excess of the kinds and amounts specified in the PEHP Master Policy and the Benefits Summary. You are always free to personally obtain and pay for services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment outside of the coverage provided to you through PEHP.

Unless otherwise noted in this Benefit Summary, the following general limitations and exclusions apply to your pharmacy and drug benefits. This is not a complete list of limitations and exclusions that apply to your coverage. See the PEHP Master Policy for a complete list of limitations and exclusions.

The following are Limitations of the policy:

1. Drug quantities, dosage levels and length of therapy may be limited by PEHP.
2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting.
3. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage.
4. When a medication is dispensed in two different strengths or dosage forms, a separate Coinsurance will be required for each dispensed prescription.
5. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation.
6. Medication quantities and availability may be restricted to a lower allowed day supply when a manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply.
7. Cash paid and Coordination of Benefits claims will be subject to PEHP's Pre-authorization, step therapy, benefit Coverage and quantity levels. PEHP will reimburse up to Express Scripts' Contracted rate and PEHP's benefit rules.
8. PEHP will have the ability to limit the availability and filling of any medication, Device or supply. The Pharmacy or Case Management Department may require the following:
   a. Require prescriptions to be filled at a specified pharmacy.
   b. Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by PEHP.
   c. Obtain services and medications from only a specified Provider.
   d. Require participation in a specified treatment for any underlying medical condition.
   e. Require completion of a drug treatment program.
   f. Adhere to a PEHP Limitation or program to help reduce or eliminate drug abuse or dependence.
   g. Deny medications or quantities needed to support any dependence, addiction or abuse if a Member misuses the health care system to obtain drugs in excess of what is Medically Necessary.
9. Fluoride tablets are limited to children up to the age of 12 years old.
10. Enteral formula requires Pre-authorization and is limited to the pharmacy network for Coverage.
11. Retail prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Prescription Drug Coverage

The following are Exclusions of the policy:

1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on PEHP's website or Master Policy.
2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
3. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old).
4. Hair growth and hair loss products.
5. Medications or nutritional supplements for weight loss or weight gain.
6. Investigational and non-FDA Approved medications.
7. Medications needed to participate in any drug research or medication study.
8. FDA-approved medication for Experimental or Investigational indications.
9. Non-approved indications determined by the PEHP Master Policy.
10. Drugs for athletic and mental performance.
11. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by PEHP.
12. Oral infant and medical formulas.
13. Therapeutic Devices or appliances.
14. Diagnostic agents.
15. Over-the-counter medications and products.
16. Take-home prescriptions from a Hospital or Skilled Nursing Facility.
17. Biological serum, blood, or blood plasma.
18. Medications and injectables prescribed for Industrial Claims and Worker's Compensation.
19. Medications dispensed from an institution or substance abuse clinic when the Member does not use their pharmacy card at a PEHP Contracted pharmacy are not payable as a pharmacy claim.
20. Compounding fees, powders, and non-covered medications used in compounded preparations.
21. Medications used for Cosmetic indications.
22. Replacement of lost, stolen or damaged medications.
23. Nasal immunizations.
24. Medications for Elective abortions except in accordance with Utah Sate Law.
25. Drugs for the treatment of nail fungus.
26. Medications for sex change operations.
27. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services.
28. Hypodermic needles.
29. Oral and nasal antihistamines for allergies.
30. Drugs used for sexual dysfunction or enhancement.
31. Medications for the treatment of infertility.
32. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP.
34. Drugs purchased from non-participating Providers over the Internet.
30. Medications obtained outside the United States.

This applies only to Utah Basic Plus. See Pages 38-49 for information that applies to The STAR Plan and Traditional plan.

Wellness and Value-Added Benefits

PEHP Healthy Utah

Subscribers and their spouses are eligible to attend one Healthy Utah testing session each plan year free of charge. Healthy Utah is offered at the discretion of the Employer.

Complete biometrics/lab screening with Healthy Utah or a physician, that includes body mass index (BMI), height, weight, blood pressure, blood glucose, cholesterol, tobacco use and waist circumference.

Complete an online health risk assessment questionnaire through www.healthyutah.org/myhu.

FOR MORE INFORMATION
PEHP Healthy Utah
801-366-7300 or 855-366-7300
» **Email: healthyutah@pehp.org**
» **Web: www.healthyutah.org/myhu**

PEHP Integrated Care

As the name suggests, PEHP Integrated Care takes a big-picture approach to your health, incorporating everything from wellness to pharmacy to education to complex care management. It's our new approach to disease management that addresses an entire spectrum of prevention and care.

It's for PEHP members with diabetes, coronary artery disease, congestive heart failure, or chronic obstructive pulmonary disease, as well as other diseases and conditions. With your permission, PEHP Integrated Care nurses will stay in touch with you by phone, secure email, and educational mailings. We'll be here to help guide you through your treatment plan and answer questions you may have about managing your condition.

FOR MORE INFORMATION
PEHP Integrated Care
801-366-7555 | 800-765-7347
» **Web: www.pehp.org**

PEHPplus

The money-saving program PEHPplus helps promote good health and save you money. It provides savings on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. Learn more at www.pehp.org/plus.

PEHP Dental Care

Introduction

PEHP wants to keep you healthy and smiling brightly. We offer dental plans that provide coverage for a full range of dental care.

When you use contracted providers, you pay a specified copayment and PEHP pays the balance. When you use non-contracted providers, PEHP pays a specified portion of the Allowed Amount (AA), and you are responsible for the balance.

There is no deductible for Diagnostic or Preventive services.

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

There is a Waiting Period of six months from the effective date of coverage for Orthodontic, Implant, and Prosthodontic benefits.

Members returning from military service will have the six-month waiting period for orthodontics waived if they reinstate their dental coverage within 90 days of their military discharge date.

Missing Tooth Exclusion

Services to replace teeth that are missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP.

However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge or denture was in place at the time the coverage became effective.

Limitations and Exclusions

Written pre-authorization may be required for prosthodontic services. Pre-authorization is not required for orthodontics.

Refer to the Dental Care Master Policy for complete benefit limitations, exclusions, and specific plan guidelines.

Master Policy

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

Preferred Dental Care

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines.

Plan year deductible is $25 per member, up to a $75 maximum per family. Does not apply to preventive or diagnostic services. Maximum Yearly Benefit per Member is $1,500.	
DIAGNOSTIC	
Periodic Oral Examinations *Non-Specialist*	100% of AA
X-rays	80% of AA
PREVENTIVE	
Cleanings and Fluoride Solutions	80% of AA
Sealants | *Permanent molars only through age 17*	80% of AA
RESTORATIVE	
Amalgam Restoration	80% of AA after deductible
Composite Restoration	80% of AA after deductible
ENDODONICS	
Pulpotomy	80% of AA after deductible
Root Canal	80% of AA after deductible
PERIODONTICS	80% of AA after deductible
ORAL SURGERY	
Extractions	80% of AA after deductible
ANESTHESIA	
General Anesthesia *in conjunction with oral surgery or impacted teeth only*	80% of AA after deductible
PROSTHODONTIC BENEFITS	
Pre-authorization may be required	
Crowns	50% of AA after deductible
Bridges	50% of AA after deductible
Dentures (partial)	50% of AA after deductible
Dentures (full)	50% of AA after deductible
IMPLANTS	
All related services	50% of AA after deductible

ORTHODONTIC BENEFITS	
Maximum Lifetime Benefit per member is $1,500.	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum after deductible

AA = Allowed Amount

Traditional Dental Care

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines.

Maximum Yearly Benefit per member is $1,500.	
DIAGNOSTIC	
Periodic Oral Examinations	80% of AA
X-rays	80% of AA
PREVENTIVE	
Cleanings and Fluoride Solutions	80% of AA
Sealants | *Permanent molars only through age 17*	80% of AA
RESTORATIVE	
Amalgam Restoration	80% of AA
Composite Restoration	80% of AA
ENDODONICS	
Pulpotomy	80% of AA
Root Canal	80% of AA
PERIODONTICS	80% of AA
ORAL SURGERY	
Extractions	80% of AA
ANESTHESIA	
General Anesthesia *in conjunction with oral surgery or impacted teeth only*	80% of AA
PROSTHODONTIC BENEFITS	
Pre-authorization may be required	
Crowns	50% of AA
Bridges	50% of AA
Dentures (partial)	50% of AA
Dentures (full)	50% of AA
IMPLANTS	
All related services	50% of AA

ORTHODONTIC BENEFITS	
Maximum Lifetime Benefit per member is $1,500.	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum

Regence Expressions Dental Benefits Summary

This is a partial summary of benefits only and in the event of any inconsistency between this summary and Your Booklet, the terms of the Booklet will prevail. The Booklet contains a complete detail of benefits, limitations and exclusions, and also describes grievance procedures.

Benefit	Contracting Dentist	Non-contracting Dentist
Maximum Benefit	$1,500 per Enrollee per Plan Year for Covered Dental Services; $500 per Plan Year and $1,500 per Lifetime for each Enrollee for Orthodontic Dental Services	
Plan Year Deductible	Not applicable.	Not applicable.
Preventive and Diagnostic Dental Services		
• Oral examinations (2 per Plan Year) • Prophylaxis treatment (2 per Plan Year) • X-rays (full mouth limited to one per 3 year period) • Topical fluoride treatment (to age 26; 2 per Plan Year) • Sealants for permanent molars (to age 15) • Space maintainers (to age 13)	We pay 100% of Eligible Dental Expenses.	We pay 100% of Eligible Dental Expenses and You pay balance of billed charges.
Basic Dental Services		
Restorative Services • Extractions • Fillings consisting of composite and amalgam restoration • Emergency palliative treatment • Repair of dentures and bridges • Anesthesia **Periodontic Services** • Surgical periodontic examination • Subgingival and gingival curettage • Osseous and mucogingivoplastic surgery • Gingivectomy and gingivoplasty • Management of acute infection and oral lesions **Endodontic Services** • Pulpotomy • Pulp Capping • Root canal treatment • Apicoectomy	We pay 80% and You pay 20% of Eligible Dental Expenses.	We pay 80% of Eligible Dental Expenses and You pay balance of billed charges.
Prosthodontic Dental Services		
• Inlays, onlays and crowns • Bridges, fixed and removable • Dental implants • Dentures, full and partial • Vestibuloplasty	We pay 50% and You pay 50% of Eligible Dental Expenses.	We pay 50% of Eligible Dental Expenses and You pay balance of billed charge.
Orthodontic Dental Services		
• $500 Maximum per Enrollee per Plan Year • $1,500 Lifetime Maximum per Enrollee	We pay 50% and You pay 50% of Eligible Dental Expenses.	We pay 50% of Eligible Dental Expenses and You pay balance of billed charges.

Limitations

- For gold inlays, onlays and crowns, payment is limited to the amount that would have been paid for plastic inlays, onlays and crowns unless special need is demonstrated for use of gold.
- For other types of fillings (such as gold foil), the amount payable will be limited to the amount that would have been allowed for an amalgam restoration

What is Not Covered—This is only a partial summary of exclusions. The Booklet contains a complete list of exclusions.

- Appliances or restorations necessary to increase vertical dimensions or to restore occlusion
- Dental services for which the Enrollee incurs no charge
- Gold foil restoration
- Orthodontic Dental Services deemed to have been performed after termination of coverage hereunder or after orthodontic treatment has been terminated for any reason
- Replacement of dentures less than five years old
- Replacement of lost or stolen dentures (full or partial)
- Replacement or repair of orthodontic appliances
- Services for congential malformations; primarily for cosmetic purposes
- Services or supplies covered by worker's compensation law, employer's liability law, or furnished by any federal or state agency or other political subdivision
- Services rendered after termination of coverage; except for prostheric devices which were fitted and ordered prior to termination and were delivered within thirty days after termination date Services not specified as Covered Dental Services
- Services rendered by a dentist beyond the scope of his/her license
- Services rendered prior to the Enrollee's Effective Date. With respect to Prosthodontic Services in connection with a course of treatment begun prior to the Effective Date, services will be excluded even if some such services were rendered after your Effective Date
- Services received from a dental or medical department maintained by or on behalf of an employer
- Temporomandibular joint dysfunction
- Upper and lower jaw augmentation or reduction procedures (orthognathic surgery)

Regence

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PEHP Life and Accident

PEHP offers two ways to assure your loved-ones' well-being in the event of your death or disability.

PEHP Term Life offers up to $450,000 of coverage. You may also apply for coverage for your spouse and/or dependent children.

PEHP Group Accident Plan provides benefits:

» For death due to an accident on or off the job;

» For permanent loss of speech, hearing, eyesight, or limb function due to an accident;

» To supplement lost wages;

» To cover out-of-pocket expenses beyond what your medical plan pays.

Don't wait another day to protect yourself and your family from the unforeseen.

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no change to you.

COVERAGE	AMOUNT
Up to Age 70	25,000
Age 71 to 75	12,500
Age 76 and over	6,250

LINE-OF-DUTY DEATH BENEFIT

If you're enrolled in basic coverage, you get an additional $50,000 Line-of-Duty Death Benefit at no extra cost. Enrollment is automatic.

ACCIDENTAL DEATH RIDER

If you're enrolled in basic coverage, you get an additional $20,000 Accidental Death Benefit at no extra cost. Enrollment is automatic.

EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

» You want more coverage than the guaranteed issue.

» You apply for any amount of coverage 60 days after your hire date.

After you apply for coverage, PEHP will guide you through the necessary steps to get evidence of insurability. They may include:

» Completing a health questionnaire.

» Basic biometric testing and blood work.

» Furnishing your medical records.

EMPLOYEE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date, you can buy up to $150,000 as guaranteed issue. After 60 days or for coverage greater than $150,000 you must provide evidence of insurability.

Biweekly Rates	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.16	1.75	2.30	3.46	4.62	5.78	6.94	8.06	9.22	10.37	11.52
Age 30 to 35	1.23	1.86	2.47	3.68	4.92	6.15	7.38	8.60	9.83	11.05	12.28
Age 36 to 40	1.73	2.61	3.48	5.21	6.94	8.69	10.42	12.15	13.90	15.63	17.36
Age 41 to 45	2.12	3.20	4.25	6.37	8.51	10.62	12.76	14.86	16.99	19.11	21.23
Age 46 to 50	4.03	6.04	8.06	12.08	16.11	20.14	24.16	28.19	32.22	36.23	40.27
Age 51 to 55	4.84	7.25	9.67	14.49	19.33	24.16	29.00	33.82	38.66	43.49	48.33
Age 56 to 60	7.71	11.58	15.43	23.16	30.88	38.59	46.30	54.02	61.75	69.47	77.18
Age 61 to 70	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
After age 70, rates remain constant and coverage changes											
Coverage Amounts	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
Age 71 to 75	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life and Accident

SPOUSE TERM COVERAGE

If you apply within 60 days of your hire date or date of marriage, you can buy up to $50,000 as guaranteed issue for your spouse. After 60 days or for coverage greater than $50,000 you will need evidence of insurability.

Biweekly Rates	25,000	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	0.59	1.16	1.75	2.30	3.46	4.62	5.78	6.94	8.06	9.22	10.37	11.52
Age 30 to 35	0.63	1.23	1.86	2.47	3.68	4.92	6.15	7.38	8.60	9.83	11.05	12.28
Age 36 to 40	0.88	1.73	2.61	3.48	5.21	6.94	8.69	10.42	12.15	13.90	15.63	17.36
Age 41 to 45	1.07	2.12	3.20	4.25	6.37	8.51	10.62	12.76	14.86	16.99	19.11	21.23
Age 46 to 50	2.01	4.03	6.04	8.06	12.08	16.11	20.14	24.16	28.19	32.22	36.23	40.27
Age 51 to 55	2.41	4.84	7.25	9.67	14.49	19.33	24.16	29.00	33.82	38.66	43.49	48.33
Age 56 to 60	3.85	7.71	11.58	15.43	23.16	30.88	38.59	46.30	54.02	61.75	69.47	77.18
Age 61 to 70	6.54	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
After age 70, rates remain constant and coverage changes												
Coverage Amounts	6.54	13.09	19.63	26.18	39.25	52.34	65.43	78.52	91.61	104.70	117.78	130.87
Age 71 to 75	12,500	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	6,250	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

If you apply within 60 days of your hire date, you can buy any available amount of coverage for dependent children. After 60 days, any new application for coverage or increase in coverage will require evidence of insurability. All eligible children will be covered at the same level.

Coverage Amount	5,000	10,000	15,000
Biweekly cost	0.24	0.48	0.72

PEHP Life and Accident

Accidental Death and Dismemberment (AD&D)

AD&D provides benefits for death and loss of use of limbs, speech, hearing or eyesight due to an accident, subject to the limitations of the policy.

INDIVIDUAL PLAN

You select coverage ranging from $25,000 to $250,000.

FAMILY PLAN

» You select coverage ranging from $25,000 to $250,000, and your spouse and dependents will be automatically covered as follows:

  › Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;

  › Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.

» If an injury results in any of the losses shown below within one year of the date of the accident, the plan will pay the amount shown in the opposite column. The total amount payable for all such losses as a result of any one accident will not exceed the principal sum. The principal sum applicable to the insured person is the amount specified on the enrollment form.

FOR LOSS OF	BENEFIT PAYABLE
Life	Principal Sum
Two Limbs	Principal Sum
Sight of Two Eyes	Principal Sum
Speech and Hearing (both ears)	Principal Sum
One Limb or Sight of One Eye	Half Principal Sum
Speech or Hearing (one ear)	Half Principal Sum
Use of Two Limbs	Principal Sum
Use of One Limb	Half Principal Sum
Thumb and Index Finger On Same Hand	Quarter Principal Sum

AD&D Coverage and Cost

INDIVIDUAL PLAN				FAMILY PLAN		
Coverage Amount	Biweekly Cost	Semi-Monthly Cost	Monthly Cost	Biweekly Cost	Semi-Monthly Cost	Monthly Cost
25,000	0.43	0.46	0.92	0.58	0.62	1.24
50,000	0.85	0.92	1.84	1.14	1.24	2.48
75,000	1.28	1.38	2.76	1.72	1.86	3.72
100,000	1.69	1.84	3.68	2.28	2.48	4.96
125,000	2.12	2.30	4.60	2.85	3.10	6.20
150,000	2.54	2.76	5.52	3.42	3.72	7.44
175,000	2.97	3.24	6.48	3.99	4.34	8.68
200,000	3.39	3.68	7.36	4.57	4.96	9.92
225,000	3.82	4.14	8.28	5.13	5.58	11.16
250,000	4.23	4.60	9.20	5.71	6.20	12.40

LIMITATIONS AND EXCLUSIONS

Refer to the Group Term Life and Accident Plan Master Policy for details on plan limitations and exclusions. Call 801-366-7495 or visit www.pehp.org for details.

PEHP Life and Accident

Accident Weekly Indemnity

» Employee coverage only

» If you enroll in AD&D, you may also buy Accident Weekly Indemnity, which provides a weekly income if you are totally disabled due to an accident that is not job related.

» The maximum eligible weekly amount is based on your monthly gross salary at the time of enrollment. You may buy coverage less than the eligible monthly gross salary, but may not exceed the eligible monthly gross salary.

Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	BIWEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
250 and under	25	0.12	0.14	0.28
251 to 599	50	0.24	0.26	0.52
600 to 700	75	0.35	0.38	0.76
701 to 875	100	0.46	0.50	1.00
876 to 1,050	125	0.58	0.64	1.28
1,051 to 1,200	150	0.70	0.76	1.52
1,201 to 1,450	175	0.81	0.88	1.76
1,451 to 1,600	200	0.93	1.02	2.04
1,601 to 1,800	225	1.04	1.14	2.28
1,801 to 2,164	250	1.16	1.26	2.52
2,165 to 2,499	300	1.39	1.50	3.02
2,500 to 2,899	350	1.62	1.76	3.52
2,900 to 3,599	400	1.86	2.02	4.04
3,600 and over	500	2.32	2.52	5.04

Accident Medical Expense

» Employee coverage only

» Helps you pay for medical expenses in excess of those covered by all group insurance plans and no-fault automobile insurance.

» Will provide up to $2,500 to help cover medical expenses incurred due to an accident that is not job related.

Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	BIWEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
$ 2,500	$ 0.38	$ 0.42	$ 0.84

Master Policy

This brochure provides only a brief overview. Complete terms and conditions governing these plans are available in the Group Term Life and Accident Plan Master Policy. It's available via myPEHP at www.pehp.org. Contact PEHP to request a copy.

PEHP Long-Term Disability

Did you know that you may have a Long-Term Disability (LTD) benefit paid for by your employer?

The PEHP LTD benefit may pay a portion of your salary and medical coverage if you have an accident, disease, illness, or are physically disabled due to a line-of-duty related injury. To qualify for LTD you must be disabled and unable to return to work for more than 90 days. The application process should begin when you stop working.

You must apply for LTD within six months from your last day worked in your regular job.

For more information, visit www.pehp.org and login to myPEHP. Or contact the PEHP LTD department at: 801-366-7583 or 800-365-7347.

PEHP Flexible Spending Plan — FLEX$

Save Money With FLEX$

Sign up for PEHP's flexible spending account – FLEX$ — and save. FLEX$ saves you money by reducing your taxable income. Each year you set aside a portion of your pre-tax salary for your account. That money can be used to pay eligible out-of-pocket health expenses and dependent day care expenses.

FLEX$ Options

FLEX$ has two options, one for medical expenses and another for dependent day care. You may contribute a minimum of $130 and a maximum of $2,500 a year for healthcare expenses and up to $5,000 a year for dependent daycare expenses.

FLEX$ HEALTH CARE ACCOUNT

Use this account to pay for eligible out-of-pocket health expenses for you or your eligible dependents. Pay for such things as out-of-pocket deductibles and copayments, prescription glasses, laser eye surgery, and more. Go to www.pehp.org for a list of eligible items.

FLEX$ DEPENDENT DAY CARE ACCOUNT

This account may be used for eligible day-care expenses for your eligible dependents to allow you or your spouse to work or to look for work.

Using Your FLEX$ Card

You will automatically receive a FLEX$ Benefit Card at no extra cost. It works just like a credit card and is accepted at most eligible merchants that take MasterCard.

Use the card at participating locations and your eligible charges will automatically deduct from your FLEX$ account.

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

You will be responsible to keep all receipts for tax and audit purposes. Also, PEHP may ask for verification of any charges.

Important Considerations

- You must plan ahead wisely and set aside only what you will need for eligible expenses each year. FLEX$ is a use-it-or-lose-it program – money does not carry over from year to year.
- The total amount you elect to withhold throughout the year for medical expenses will be immediately available as soon as the plan year begins.
- You can't contribute to a health savings account (HSA) while you're enrolled in healthcare FLEX$. However, you may have a dependent day care FLEX$ or a limited FSA and contribute to an HSA.

Enrollment

ENROLL ONLINE

Log in to myPEHP at www.pehp.org.
Click on online enrollment.

EyeMed
VISION CARE®

Enroll Today in a Convenient and Affordable Vision Care Plan

You get vision wellness for you and your family.

Regular eye exams measure your eyesight and they can also detect other serious illnesses like diabetes, heart disease and high blood pressure.

You get great savings of approximately 40% with only a $10 eye exam copay.

Save on eye exams, eyeglasses and contacts with vision coverage through your EyeMed plan. Also enjoy unlimited additional savings of 40%.

You get convenience and choice.

Use your benefit at thousands of private practice and leading optical retail locations close to where you live, work and shop.

Enroll today! For more information, see plan details on next page.

Private Practitioners

LENSCRAFTERS®

PEARLE VISION®

Sears Optical

OPTICAL®

JCPenney
jcp.com

EyeMed VISION CARE®

PEHP

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $35
Contact Lens Fit and Follow-Up *(Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)*		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Frames	$0 Copay, $100 Allowance; 20% off balance over $100	Up to $50
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $55
Standard Progressive Lens	$75	Up to $40
Premium Progressive Lens	$75, 80% of charge less $120 Allowance	Up to $40
Lenticular	$10 Copay	Up to $55
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate—Adults	$40	N/A
Standard Polycarbonate—Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses *(allowance includes materials only)*		
Conventional	$0 Copay, $120 Allowance; 15% off balance over $120	Up to $96
Disposable	$0 Copay, $120 Allowance; plus balance over $120	Up to $96
Medically Necessary	$0 Copay, Paid in full	Up to $200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used.	
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Premiums		
Singles	$9.06	
Double	$15.24	
Family	$21.40	

Want to learn more?

- For a complete list of providers near you, use our Provider Locator on www.eyemedvisioncare.com and choose the ACCESS network or call 1-866-723-0596.
- For Lasik providers, call 1-877-5LASER6.

Additional Discounts and Features:

- 40% off additional eyewear purchases.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.
- Laser vision correction—15% off the retail price or 5% off the promotional price for Lasik or PRK procedures.

LensCrafters Pearle Vision Sears Optical OPTICAL JCPenney Optical Private Practitioners

Opticare of Utah

Why Opticare of Utah?

Eyes are the window to the entire body.

Americans typically visit the doctor only when they have a problem. But if you visit the doctor only when symptoms start showing, it may be too late. In fact, the five leading causes of death, as reported by the CDC, are nearly irreversible and incurable when diagnosed late:

- Heart Disease
- Cancer
- Cerebrovascular Diseases (Stroke)
- Diabetes
- Nephritis / Kidney Diseases including Lupus

Routine exams are relatively inexpensive and often covered by insurance, and an OD can catch diabetes, hypertension, high blood pressure, cerebrovascular disease, cancer, auto-immune diseases, and each one of these leading causes of death.

Why you should have vision insurance: health reasons

Visual disorders are the second most prevalent health problem in the country, affecting over 130M people.

- 2/3 of all adults have a vision disorder that can be treated simply by glasses.
- Age Related Macular Degeneration (AMD) and Glaucoma are sight threatening diseases that cause 2M people to go blind annually.
- 90% of computer users have a vision related disorder; treated or untreated, and computer vision syndrome can cause migraines, contrast sensitivity and dry eye syndrome.

Why you should have vision insurance: financial reasons

Patients without vision insurance pay approximately $275 more per year than those that have a plan.

Other benefits.

- RICH LASIK discount at Standard Optical ($500 off per eye).
- Easy online access to providers nationwide: www.opticareofutah.com
- Additional discounts throughout the year once benefits have been used.
- Most importantly we are LOCAL and here to support you whenever needed.

Standard Optical — Where Good Vision is Always in Fashion.

America's Best Contacts & Eyeglasses

ShopKo Stores Inc.

FirstLook Vision Network

Independent Optometry Network

Visionworks

Opticare Plan: 10-120C

PEHP State of Utah	**Select Network**	**Broad Network**	**Out-of-network**
Eye Exam			
Eyeglass exam	$10 Co-pay	$15 Co-pay	♦$40 Allowance
Contact exam	$10 Co-pay	$15 Co-pay	♦$40 Allowance
Dilation	100% Covered	Retail	Included above
Contact Fitting	100% Covered	Retail	Included above
Standard Plastic Lenses			
Single Vision	100% Covered	$10 Co-pay	◆$85 Allowance for lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$10 Co-pay	
Trifocal (FT 7x28)	100% Covered	$10 Co-pay	
Lens Options			
*Progressive *(Standard plastic no-line)*	$30 Co-pay	$50 Co-pay	
*Premium Progressive Options	20% Discount	No Discount	
*Glass lenses	15% Discount	15% Discount	
Polycarbonate	$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount	
Coatings			
Scratch Resistant Coating	100% Covered	$10 Co-pay	
Ultra Violet protection	100% Covered	$10 Co-pay	
Other Options *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	Up to 25% Discount	
Frames			
Allowance Based on Retail Pricing	$120 Allowance	$100 Allowance	◆$80 Allowance
Additional Eyewear			
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	Up to 25% Off Retail	
Contacts			
Contact benefits is in lieu Of lens and frame benefit.	$120 Allowance	$100 Allowance	◆$80 Allowance
Additional contact purchases:			
***Conventional	Up to 20% off	Retail	
***Disposables	Up to 10% off	Retail	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Refractive Surgery			
****LASIK	$500 Off Per Eye	Not Covered	Not Covered

**Co-pays for Progressive lenses may vary. This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.*

Discounts

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

*** 50% discount at Standard Optical locations only. All other Network discounts vary from 20% - 35%.*

****Must purchase full year supply to receive discounts on select brands. See provider for details.*

******LASIK(Refractive surgery) Standard Optical Locations ONLY.** *LASIK services are not an insured benefit – this is a discount only.*

All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.

◆***Out of Network*** *– Allowances are reimbursed at 75% when discounts are applied to merchandise. Promotional items or Online purchases not covered.*

For more Information please visit www.opticareofutah.com or call 800-363-0950

Opticare enrollment change: A dependant may not enroll in the benefit without the employee being enrolled.

BLOMQUIST HALE
EMPLOYEE ASSISTANCE

Life Assistance Counseling

PEHP has Selected Blomquist Hale Employee Assistance as the Exclusive Provider for Your Life Assistance Benefit

Licensed Professional Clinicians

100% Confidential

Convenient Locations

Who Is Eligible?

All State and Quasi-State Risk Pool employees with PEHP Traditional and PEHP STAR medical plans, and their covered dependents, are eligible to receive Life Assistance counseling services with no co-pay or fees. PEHP pays 100% of the cost of the Life Assistance Counseling care.

Brief, Solution-Focused Therapy

At Blomquist Hale, we use a brief, solution-focused therapy model to resolve problems quickly. Using this approach, clients take more responsibility in learning how to resolve their own problems than in traditional therapy. If a more intensive level of service is needed, a Blomquist Hale counselor will assist you in finding the appropriate resource. Blomquist Hale does not cover the costs of referred services.

Confidentiality

Blomquist Hale practices strict adherence to all professional, state and federal confidentiality guidelines. Confidentiality is guaranteed to all participants.

How to Access the Service

Access is as simple as calling and scheduling an appointment. No paperwork or approval is needed! All that is required is your PEHP ID number, to verify that you are eligible for these services.

** Excludes Utah Basic Plus Plan Members*

Salt Lake City 801-262-9619
Ogden 801-392-6833
Orem 801-225-9222
Brigham City 435-723-1610
Logan 435-752-3241

Call Our Local Offices or Toll Free 1-800-926-9619

Utah Educational Savings Plan

A tax-advantaged program to save for higher education

A child with a college savings account is seven times more likely to pursue higher education.*

It's just one of the benefits your family receives when you save for your child's future higher education expenses with the Utah Educational Savings Plan (UESP), Utah's official nonprofit 529 college savings program.

Following is a basic overview of UESP. Please read the UESP Program Description (available at uesp.org or by calling 800.418.2551) for complete details. With UESP:

Save what you can, when you can.

UESP requires no minimum deposits or balances to open an account, so you can save according to your own schedule.

Enjoy tax benefits.

Earnings on UESP accounts grow tax deferred and are federal and Utah state income tax free when used for qualified higher education expenses such as:

- Tuition and fees
- Required books and supplies
- Certain room and board costs

The funds can be used at any eligible educational institution that participates in federal financial aid programs for students, not just at institutions in Utah. (See fafsa.ed.gov for a list of eligible schools.)

Get an extra Utah State tax advantage.

Utah state income tax benefits for account owners help you get more out of your college savings. For 2013:

- Utah individual taxpayers/residents and trusts that are account owners may claim a 5 percent state income tax credit on contributions up to $1,840 per qualified beneficiary, equaling up to $92.
- Utah taxpayers married filing jointly may claim the 5 percent tax credit on contributions up to $3,680 per qualified beneficiary, equaling up to $184.
- Utah corporations are eligible for a tax deduction up to $1,840 on contributions per qualified beneficiary.

All eligible contributions to your account—not just those made by you—count toward the Utah state income tax benefits. To qualify for the tax benefits, the beneficiary on the account must be designated as such before age 19. If this requirement is met, you as the account owner are eligible to claim an income tax credit or deduction each year a contribution is made—for the life of the beneficiary's account.

Be in control.

You, rather than your beneficiary, retain control over how the money in your account is invested and when it is withdrawn. If circumstances change—for example, your daughter gets a scholarship or your son goes into the military—you can transfer the account to a member of your beneficiary's family without penalties.

If you encounter a family emergency or simply change your mind, you can withdraw your funds at any time. But if the money is used for anything other than qualified higher education expenses, you'll generally have to pay income taxes and a penalty tax on the earnings.

Choose your savings strategy.

UESP offers 12 investment options, each utilizing a distinct investment strategy. Options include:

- Age-based options that automatically change the asset allocation as your child grows
- Static options, including an FDIC-insured savings account
- Customized options that allow you to create your own investment allocation using any combination of available underlying funds

Open a UESP account and start saving today!

Each dollar saved with UESP today contributes to your child's success tomorrow. To learn more about UESP and to obtain and read a copy of a Program Description, visit uesp.org, call 800.418.2551, or e-mail info@uesp.org

**William Elliott III and Sondra Beverly, The Role of Savings and Wealth in Reducing "Wilt" between Expectations and College Attendance, Center for Social Development Research Brief (Washington University in St. Louis) No. 10-04 (January 2010): 2, http://csd.wustl.edu/Publications/Documents/RB10-04.pdf*

Read the Program Description for more information and consider all investment objectives, risks, charges, and expenses before investing. Call 800.418.2551 for a copy of the Program Description or visit uesp.org. Investments are not guaranteed by UESP, the Utah State Board of Regents, UHEAA, or any other state or federal agency. However, Federal Deposit Insurance Corporation (FDIC) insurance is provided for the FDIC-insured savings account. Please read the Program Description to learn about the FDIC-insured savings account. Your investment could lose value.

Non-Utah taxpayers and residents: You should determine whether the state in which you or your beneficiary pay taxes or live offers a 529 plan that provides state tax or other benefits not otherwise available to you by investing in UESP. You should consider such state tax treatment and benefits, if any, before investing in UESP.

"The advantages are huge."

Randy B.
UESP Account Owner

- **Free to open an account**
- **No minimum or ongoing contribution requirements**
- **Federal and Utah state tax advantages**

Utah Educational Savings Plan®

Utah's Official Nonprofit 529 College Savings Program

Open a UESP account and start saving for college today.

UPEA

Utah Public Employees' Association

You Have Rights.

Together, we protect your rights.

- UPEA is an Independent, Public Employee Advocate
- UPEA Advocates for Employees at the State Legislature
- UPEA Helps Employees During Grievance Proceedings
- UPEA Advises Employees of Their Rights
- UPEA Ensures Employers Give Employees Due Process
- UPEA Recognizes and Rewards Exceptional Employees
- UPEA Encourages and Supports Participation in the Political Process
- UPEA is the Largest Public Employee Labor Organization in Utah
- UPEA is Run Entirely by Utah Public Employees Like You
- UPEA Dues Stay 100% in the State of Utah to Support Public Employees

www.upea.net ● phone: (801) 264-8732 ● fax:(801) 264-8879

UPEA Membership Agreement/Payroll Deduction Authorization

You may fax to: (801) 264 - 8879 or Mail to: 1000 W Bellwood Ln, Murray, UT 84123

Last Name	First Name	Personal E-Mail Address			
Employer (City, County, State, Higher Ed., etc.)		Home Mailing Address		Home Phone	
Employer Address	Work Phone	City	State	Zip	
City	Zip / Work E-mail Address	Home E-mail Address	Voting Precinct	Senate District	House District

I hereby voluntarily authorize and direct my employer to deduct $15.00 per month from my paycheck and pay the same to the Utah Public Employees' Association (UPEA) as dues for membership in that organization and agree that said payroll deductions shall continue until I revoke this authorization by giving written notice to UPEA. Authorization for withholding UPEA dues will remain in effect even after retirement unless a member gives written notice to UPEA. Upon retirement this form authorizes the Utah Retirement Systems to deduct $5.00 per month from my retirement allowance. This payroll deduction authorization shall serve as my application for membership in UPEA and shall designate UPEA as my employee representative for all purposes provided by law.

X Signature	Date	Recruiter

For Office Use Only	District Number	Chapter Number	Jurisdiction Number	Low Org./Dept. No.	Confirmed Date

MetLife

State of Utah

has arranged with MetLife Auto & Home to provide auto and home insurance at competitive group rates. Special employee rates and discounts **could help you save hundreds* on auto insurance.** Plus, MetLife Auto & Home offers a convenient **payroll deduction** payment option!

MetLife Auto & Home offers a complete line of policies that complement one another – without any gaps, hidden charges or surprises:

Auto — Personal liability and property insurance for automobiles at special group rates, with convenient payment options, multi-car discounts, safety device discounts, claim-free discounts, and more.

Home[1]/Condo[1] — Personal liability and property insurance, covering loss, repairs and/or replacement of a damaged home/condo and/or its contents.

Renters[1] — Personal liability and property insurance for renters, with a variety of coverages and customized features (not available in Florida).

Boat Insurance — Coverage for boat, personal liability and personal effects.

Landlord's Rental Dwelling[1] — Protection from financial hardship for landlords with dwellings built for one to four families, should unforeseen events occur. Inflation Protection adjusts the coverage limit available to guard against unexpected increases in building and repair costs incurred due to a covered loss. Coverage A Plus, which provided replacement cost for the dwelling, even if the cost to repair exceeds the Coverage A limit, subject, of course, to your deductible[2] and loss of rental income are also available.

Motor Home[1] — Protection for mobile/motor homes, including physical damage coverage, liability coverage, medical payments coverage and more.

Motorcycle — Coverage for insureds in the event of an accident with a motorcycle, including physical damage coverage, liability coverage, medical payments coverage and more.

Recreational Vehicle (RV) — Coverage for insureds in the event of an accident with their motor home, camper trailer, snowmobile, or other recreational vehicle, including physical damage coverage, liability coverage, medical payments coverage and more.

Personal Excess Liability — Provides coverage over your primary auto and home insurance. Added protection if you are held liable for injury to others involving a covered auto.[3] PELP also covers you for libel and slander, risks not generally covered by standard homeowner's policies.

For free, no-obligation quotes, and to apply for coverage call 1 800 Get-Met 8 (1-800-434-6388). A MetLife Auto & Home insurance consultant will help you apply for coverage and answer all of your questions. To make accurate comparisons, please have your current insurance policies with you when you call.

* Savings are based on an annualized average savings for a group auto policy where the customer provided his/her prior premium and prior carrier at the time of the original quote between 01/12 and 12/12 and where the MetLife Auto & Home written auto premium amount resulted in a price less than the disclosed prior carrier's premium.

[1] Homeowners coverage in California and Florida is not part of this voluntary benefit offering. However, Renters and Condo coverage are available as part of the program in California.

[2] Restrictions may apply. Not available in all states and subject to a cap in states such as Florida.

[3] Increased limits of liability over and above the limits of auto, boat, snowmobile or RV policies.

MetLife Auto & Home is a brand of Metropolitan Property and Casualty Insurance Company and its affiliates: Metropolitan General Insurance Company, Metropolitan Group Property and Casualty Insurance Company, and Metropolitan Lloyds Insurance Company of Texas, all with administrative home offices in Warwick, RI. Coverage, rates, and discounts are available in most states to those who qualify.

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MetLife Auto & Home
700 Quaker Lane
PO Box 350
Warwick, RI 02887
www.metlife.com

Stretch your fitness dollars, spring for the latest Smartphone, or pay down your student loans…whatever moves you most.

As an employee of the State of Utah, you could **save up to $343.90*** on your auto insurance with Liberty Mutual. You could also enjoy valuable discounts tailored to the way you live today and save even more by insuring your home as well.

Responsibility. What's your policy?

CONTACT US TODAY TO START SAVING		
CALL	800-835-0894	Client # 110225
CLICK	LibertyMutual.com/utah	
COME IN	to your local office	

Liberty Mutual INSURANCE

AUTO | HOME

* Discounts are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Savings figure based on a February 2011 sample of auto policyholder savings when comparing their former premium with those of Liberty Mutual's group auto and home program. Individual premiums and savings will vary. Coverage provided and underwritten by Liberty Mutual Insurance and its affiliates, 175 Berkeley Street, Boston, MA. © 2012 Liberty Mutual Insurance.

Here's One More Great Benefit:

State of Utah Employees are Eligible to Join Security Service!

Since 1956, Security Service has helped members meet their financial needs. Backed by $6.9 billion in assets, Security Service offers a full spectrum of competitive financial products and services, including:

- Checking and Savings Accounts
- Home and Auto Loans
- Credit Cards and Lines of Credit
- CDs and Investment Services
- Business Accounts and Commercial Loans

Plus, Security Service members enjoy nationwide account access at more than 5,000 credit union locations through our partnership with the Shared Branching Network and nearly 30,000 free CO-OP Network ATMs.

To join Security Service:

Go to ***ssfcu.org***

Call us 24/7/365 at ***1-888-415-7878***

Stop by one of our 14 Utah locations—visit ***ssfcu.org/locations*** to find a branch near you.

SECURITY SERVICE
FEDERAL CREDIT UNION

Membership eligibility required. State of Utah employees are eligible for membership. Family members of eligible persons may also join. Federally insured by the NCUA. Equal Housing Lender. Qualified borrowers only. Usual credit criteria apply. Terms and conditions may vary.

State of Utah Employees

Here's an Affordable Solution to Help with Your Legal Needs

Finding an affordably priced lawyer to represent you for consumer protection matters or even to prepare your will can be a challenge. And now there's an easy, affordable solution —— the Group Legal Plan, administered by Hyatt Legal Plans. You, your spouse, and dependents can have access to a lawyer at a price that won't break your budget.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With the Group Legal Plan, you can receive legal representation or advice for a wide range of legal matters, including*:

Wills and Estate Planning
- Living Wills
- Powers of Attorney
- Wills and codicils
- Trusts

Debt Matters
- Debt collection defense
- Personal bankruptcy
- Identity theft defense

Defense of Civil Lawsuits
- Administrative hearings
- Civil litigation defense
- Incompetency defense

Reduced Fees
Network attorneys provide representation for: personal injury; probate and estate administration matters at reduced fees

Real Estate Matters
- Eviction defense
- Tenant negotiations
- Security deposit assistance (for tenant)

Consumer Protection
- Consumer protection matters
- Small claims assistance

Document Review
- Any personal legal document

Juvenile Matters
- Juvenile defense

Family Law
- Name change
- Premarital agreement
- Uncontested adoption
- Uncontested guardianship
- Uncontested divorce

Document Preparation
- Affidavits
- Deeds
- Demand letters
- Mortgages
- Promissory notes

Traffic Matters
- Traffic defense (excludes DUI)
- Driving privileges restoration

$21.25 per employee per month —— covers you, your spouse, and dependents

Telephone advice and office consultations for virtually any personal legal matter with an attorney of your choice

E-Services —— Attorney locator; law firm e-panel; law guide; free, downloadable legal documents; financial planning, insurance and work/life resources

Discover how affordable and convenient it can be to get legal representation
- No waiting periods, dollar caps or hour limits for covered services performed by network attorneys.
- Participants have the freedom to choose an out-of-network attorney and be reimbursed according to a set fee schedule**.

Enroll By June 14, 2013. Here's how:

Call us at 1-800-GET-MET 8 or return the enrollment form provided

Enrollment forms can also be found on the Employee Gateway.

Your cost for the Plan will then automatically be deducted from your paychecks.
Once you enroll, you must remain in the Plan for the entire Plan year.

If you are already enrolled in the Plan, your coverage will be automatically renewed unless you call **1- 800-GET-MET 8** (1-800-438-6388) to cancel the coverage.

For access to affordable, convenient legal services, turn to the Group Legal Plan available through your employer

Join Today!

For more information call 1-800-GET-MET 8

Hyatt Legal Plans
A MetLife Company

Cost to Employee: only $21.25 a month

Your Hire Date_____

Your Name: _____
First *Middle* *Last*

Your Social Security Number: _____

Your Home Address: _____
Street

_____
City *State* *Zip*

6 Digit State of Utah Employee Number (Required):

_____

Dept. No./Div. Code (if applicable): _____

I hereby elect to enroll in The Group Legal Plan effective, July 1, 2013. I understand that my election will remain in effect for the entire plan year, or until I am no longer an eligible employee or my employment with State of Utah is terminated. I authorize the State of Utah to take the appropriate after-tax payroll deductions ($21.25/month, $9.80/bi-weekly) needed to maintain this election. I understand that once enrolled in the Plan, my coverage will be automatically renewed unless I call 1 800 GET-MET 8 (1-800-438-6388) to cancel my coverage during the open enrollment period.

Signature _____
(Required for processing) *Date*

State of Utah

Enroll now. Here's how:

Call: 1 800 GET-MET 8
or
Fax to (908) 655-9731 during Open Enrollment

The Enrollment Period Ends June 14, 2013

Group legal plans and Family Matters provided by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, Ohio. In certain states, group legal plans and Family Matters are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, RI.

All services not available in all states.
No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. **For Family Matters, different terms and exclusions apply.

MetLaw® and MetLife® are registered trademarks of Metropolitan Life Insurance Company, New York, NY. L0312245152[exp0513][All States][DC]

TheStandard®

State of Utah – Voluntary Short Term Disability Insurance

Features of the Disability Plan:

- Replaces 60% of your gross weekly earnings in the event of a Non-Occupational Accident or Illness (including pregnancy)
- Weekly Benefit Maximum: $1,500 per week
- Payable for up to 90 Days or when your Long Term Disability begins
- Plan Allows Flexibility:
  - Choose from 2 Plans: Option 1: 7 Day Waiting Period
    Option 2: 30 Day Waiting Period
    (Waiting period is based on calendar days)

- **NOTE: If you did not sign up for this coverage when you were initially eligible as a new member you will be subject to the Late Enrollment Penalty***
- **Enrollment into the plan and any plan changes can be done throughout the year subject to enrollment penalties***
- **However, you can only terminate your participation in this program at each Annual Enrollment period**

Voluntary Short Term Disability Advantages:

- Receive both your Voluntary Short Term Disability Benefits & Annual Leave
- No Evidence of Insurability – No Pre-Existing Condition Provisions
- Tax Free Benefit
- Easy Enrollment - On line enrollment available at www.standard.com/enroll. Or complete the application included in the PEHP booklet and return the completed form to your payroll agency representative

Affordable Premiums through Payroll Deduction:

- Premiums Based on your Age and your gross Weekly earnings
- Example: You make $ 42,000 a year and are age 43

  - Option 1 (7 Day Wait): Premium would be $20.37 bi-weekly
  - Tax Free Weekly Benefit: $485 Per Week

  - Option 2 (30 Day Wait): Premium would be $8.49 bi-weekly
  - Tax Free Weekly Benefit: $485 Per Week

For More Details: See State of Utah Gateway Site or go to www.standard.com/enroll to obtain Voluntary Short Term Disability Employee Brochure

***Late Enrollment Penalty: If you have an illness (including pregnancy) during the first twelve months of being insured, your waiting period will be 60 days regardless of the plan you elect. Once you have been enrolled in the plan for 1 year the late enrollment penalty will end. Accidents will be payable at the plan option you elected. If you change plans from 30 days to 7 days, please be aware that during the first 12 months of the change if you have a disability caused by illness your waiting period will still be 30**

Standard Insurance Company **Enrollment and Change Form**

Please mark all boxes, complete all sections that apply, and return to your Human Resources Representative. Be sure to sign and date your Enrollment and Change form.

Beginning with your annual enrollment period for 2011 elections, you may elect to discontinue your participation in this plan each annual enrollment period with an effective date of July 1st of each year.

Note: You may also enroll online at www.standard.com/enroll.

Human Resources Representative, complete the last section and return completed form to The Standard by fax (888) 644-6814.

APPLICANT

Your Name (Last, First, Middle)		Group Name **State of Utah**	Employee/Member ID No.	Group Number(s) **646597**	
Your Address		City		State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation		

DISABILITY

Short Term Disability

Voluntary STD

☐ Option 1: 7 Day Waiting Period ☐ Option 2: 30 Day Waiting Period

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change Former name _____ ☐ Other _____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Human Resources - Complete this section. Retain form for your records.

Dept #	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $_____ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr

We are Members of the **Utah *Alliance* of Government Employees** asking you to join with us to create positive change. It's a fact that when people work on common issues, we will have more success than one of us doing it alone. Our pay, benefits, and working conditions need you.

UAGE is not a new Idea – It's just a better Idea. The concept of joining together on common issues is not new; people of all professions are doing it. Here are just a few examples;

Utah Taxpayers Association, Utah Association of REALTORS, Utah League of Cities and Towns, Utah Bankers Association, National Governors Association, Utah Association of Counties, Utah City Management Association… ***It works for them – let's let it works for us!***

Join With Us – Join UAGE - Your Voice Matters

Please Check One:	☐ I am a Civilian employee and will pay **$9.23**	☐ I am a Sworn Officer and will Pay **$11.08** * Sworn Officers have an additional insurance for on the job incidents. **Only available though UAGE**

I hereby authorize you to deduct from my earnings each pay period the amount indicated above or an amount as may be established in the future by the board of directors. I also authorize access of my employment records for the sole purpose of maintaining my correct address and phone number.

Name _____

Address _____

City, State, Zip _____ Employer _____

Home Phone _____ Work Phone _____

Email Address _____

SSN or Emp ID _____ Effective Date _____

Signature _____ Date _____

Please print this form and fax it to 801.483.2444 or mail it to:

Utah Alliance of Public Employees
PO Box 456
Draper, UT 84040
801-483-1200