Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal

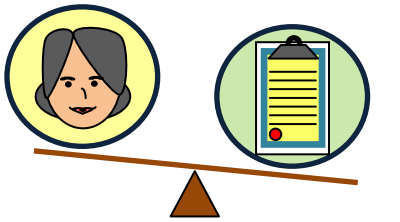
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance

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



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

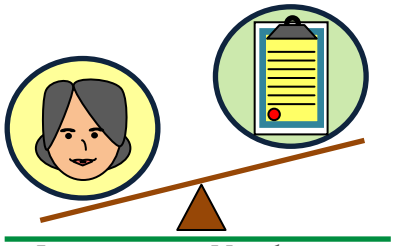
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

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

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

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

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

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

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

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

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

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

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

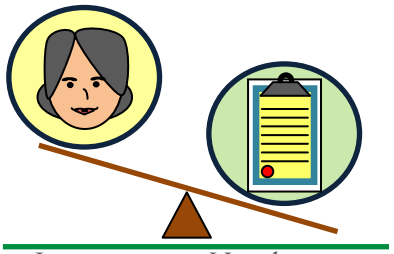
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

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

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

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

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

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

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

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

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

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

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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

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

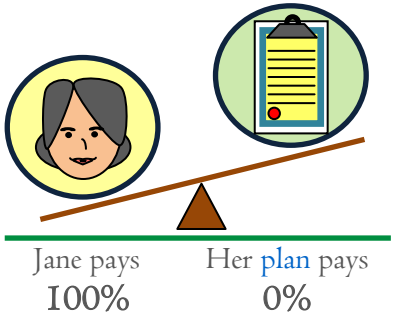
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

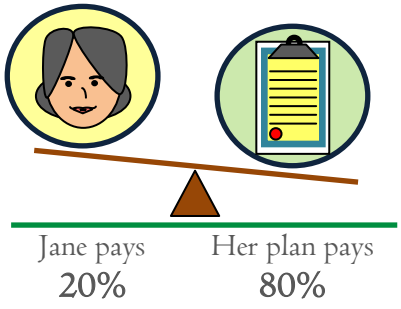


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

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

more costs

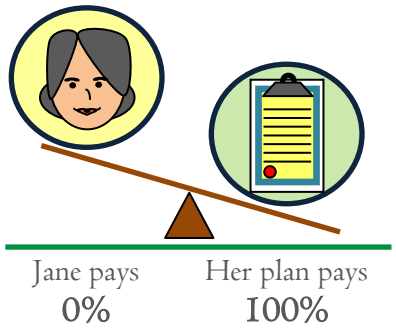


Jane reaches her $1,500 deductible, co-insurance begins

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

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



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

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

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.pehp.org or by calling 1-800-765-7347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** family for contracted and non-contracted providers. Doesn't apply to contracted provider visits or preventive care received from contracted providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, July 1st). See the chart starting on Page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on Page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Plan year out-of-pocket max:**$5,000** per person/**$10,000** per family for contracted and non-contracted providers. No out of pocket limit for non-contracted providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan doesn't cover, and out-of-network coinsurance. See Benefits Summary.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of contracted providers, go to www.pehp.org or call 1-800-765-7347.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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PEHP Health & Benefits

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Contracted Providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	40% of allowed amount (AA) after deductible	The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	$35 co-pay/visit	40% of AA after deductible	
	Other practitioner office visit	PEHP e-Care: $10 co-pay per visit Mental Health: Standard benefits apply PEHP Value Clinics: $10 co-pay per visit	n/a	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	Limited to the Affordable Care Act list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the allowed amount is under $350, 20% of AA after deductible if allowed amount is over $350	40% of AA after deductible	Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. Infertility services are payable at 50% of AA after deductible for eligible services. Genetic testing requires pre-authorization. Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	No charge if the allowed amount is under $350, 20% of AA after deductible if allowed amount is over $350	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.pehp.org.**	Generic drugs	$15 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs	$30 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs	$65 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room services	$125 co-pay	$125 co-pay plus any balance billing	None
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible	Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$45 co-pay	40% of AA after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	No coverage for take-home medications. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	$25/$35 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/visit	Full charge. Out-of-network charges are not covered	No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Mental/Behavioral health inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
	Substance use disorder outpatient services	$35 co-pay/visit	Full charge. Out-of-network charges are not covered	
	Substance use disorder inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
If you are pregnant	Prenatal and postnatal care	20% of AA after deductible	40% of AA after deductible	Mother and baby's charges are separate
	Delivery and all inpatient services	20% of AA after deductible	40% of AA after deductible	
If you need help recovering or have other special health needs	Home health care	No charge for skilled nursing visit	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible or $35 co-pay/visit	40% of AA after deductible	Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered.
	Habilitation services	20% of AA after deductible or $35 co-pay/visit	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	Sleep disorder equipment/supplies are limited to $2,500 in a 5-year period. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equipment or unlicensed providers of equipment.
	Hospice service	No charge	40% of AA after deductible	Requires pre-authorization. 6 months in a 3-year period maximum.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Over age 5 and adults: $35 co-pay per visit.	40% of AA after deductible	One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for Contracted providers.
	Glasses	Full charge	Full charge	Not covered under this plan.
	Dental check-up	Full charge	Full charge	Not covered under this plan.

Excluded Services & Other Covered Services:

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

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Coverage provided outside the U.S.	• Routine eye care (Adults and children, exams only)
• Long-term care	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage. **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-765-7347.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-765-7347.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-765-7347.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-765-7347.]

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,432
- **Patient pays** $2,108

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$750
Copays	$0
Coinsurance	$1,358
Limits or exclusions	$0
Total	**$2,108**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$750
Copays	$0
Coinsurance	$930
Limits or exclusions	$0
Total	**$1,680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.pehp.org or by calling 1-800-765-7347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family for contracted and non-contracted providers. Doesn't apply to contracted provider visits or preventive care received from contracted providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, July 1st). See the chart starting on Page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on Page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Plan year out-of-pocket max: **$6,000** per person/**$12,000** per family for contracted and non-contracted providers. No out of pocket limit for non-contracted providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan doesn't cover, and out-of-network coinsurance. See Benefits Summary.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of contracted providers, go to www.pehp.org or call 1-800-765-7347.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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PEHP Health & Benefits

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Contracted Providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit	40% of allowed amount (AA) after deductible	The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	$40 co-pay/visit	40% of AA after deductible	
	Other practitioner office visit	PEHP e-Care: $10 co-pay per visit Mental Health: Standard benefits apply PEHP Value Clinics: $10 co-pay per visit	n/a	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	Limited to the Affordable Care Act list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the allowed amount is under $350, 20% of AA after deductible if allowed amount is over $350	40% of AA after deductible	Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. Infertility services are payable at 50% of AA after deductible for eligible services. Genetic testing requires pre-authorization. Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	No charge if the allowed amount is under $350, 20% of AA after deductible if allowed amount is over $350	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.pehp.org.**	Generic drugs	$15 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs	$30 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs	$65 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room services	$150 co-pay	$150 co-pay plus any balance billing	None
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible	Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$50 co-pay	40% of AA after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	No coverage for take-home medications. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	$30/$40 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 co-pay/visit	Full charge. Out-of-network charges are not covered	No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Mental/Behavioral health inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
	Substance use disorder outpatient services	$40 co-pay/visit	Full charge. Out-of-network charges are not covered	
	Substance use disorder inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
If you are pregnant	Prenatal and postnatal care	20% of AA after deductible	40% of AA after deductible	Mother and baby's charges are separate
	Delivery and all inpatient services	20% of AA after deductible	40% of AA after deductible	
If you need help recovering or have other special health needs	Home health care	No charge for skilled nursing visit	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered.
	Habilitation services	20% of AA after deductible or $40 co-pay/visit	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	Sleep disorder equipment/supplies are limited to $2,500 in a 5-year period. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equipment or unlicensed providers of equipment.
	Hospice service	No charge	40% of AA after deductible	Requires pre-authorization. 6 months in a 3-year period maximum.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Over age 5 and adults: $40 co-pay per visit.	40% of AA after deductible	One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for Contracted providers.
	Glasses	Full charge	Full charge	Not covered under this plan.
	Dental check-up	Full charge	Full charge	Not covered under this plan.

Excluded Services & Other Covered Services:

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

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Coverage provided outside the U.S.	• Routine eye care (Adults and children, exams only)
• Long-term care	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage. **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-765-7347.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-765-7347.]

[Chinese (中文): 如果需要中文的帮助, **请拨打这个号码** 1-800-765-7347.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-765-7347.]

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,232
- **Patient pays** $2,308

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,308
Limits or exclusions	$0
Total	**$2,308**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$880
Limits or exclusions	$0
Total	**$1,880**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.pehp.org or by calling 1-800-765-7347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** single/**$5,000** family for contracted and non-contracted providers. Doesn't apply to eligible preventive care received from contracted providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, July 1st). See the chart starting on Page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on Page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$5,000** single/**$10,000** family for contracted and non-contracted providers. Any one individual may not apply more than $6,850 toward the family Out-of-Pocket Maximum.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan doesn't cover, and out-of-network coinsurance. See Benefits Summary.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of contracted providers, go to www.pehp.org or call 1-800-765-7347.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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PEHP Health & Benefits

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Contracted Providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% of allowed amount (AA) after deductible	40% of allowed amount (AA) after deductible	The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	20% of AA after deductible	40% of AA after deductible	
	Other practitioner office visit	PEHP e-Care: $10 co-pay per visit after deductible Mental Health: Standard benefits after deductible met PEHP Value Clinics: 20% of AA after deductible	n/a	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	Limited to the Preventive Plus list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% of AA after deductible	40% of AA after deductible	Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. Infertility services are payable at 50% of AA after deductible for eligible services. Genetic testing requires pre-authorization. Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	20% of AA after deductible	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.pehp.org.**	Generic drugs	$15 co-pay after deductible/ retail	The preferred co-pay after deductible plus the difference above the discounted cost	PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs	$30 co-pay after deductible/ retail	The preferred co-pay after deductible plus the difference above the discounted cost	
	Non-preferred brand drugs	$65 co-pay after deductible/ retail	The preferred co-pay after deductible plus the difference above the discounted cost	
	Specialty drugs	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room services	20% of AA after deductible	20% of AA after deductible plus any balance billing	None
	Emergency medical transportation	20% of AA after Deductible	20% of AA after deductible	Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	20% of AA after deductible	40% of AA after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	No coverage for take-home medications. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	20% of AA after deductible	40% of AA after deductible	

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Mental/Behavioral health inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
	Substance use disorder outpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
	Substance use disorder inpatient services	20% of AA after deductible	Full charge. Out-of-network charges are not covered	
If you are pregnant	Prenatal and postnatal care	20% of AA after deductible	40% of AA after deductible	Mother and baby's charges are separate
	Delivery and all inpatient services	20% of AA after deductible	40% of AA after deductible	
If you need help recovering or have other special health needs	Home health care	20% of AA after deductible	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible	40% of AA after deductible	Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered.
	Habilitation services	20% of AA after Deductible	40% of AA after deductible	
	Skilled nursing care	20% of AA after Deductible	40% of AA after deductible	Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after Deductible	40% of AA after deductible	Sleep disorder equipment/supplies are limited to $2,500 in a 5-year period. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equipment or unlicensed providers of equipment.
	Hospice service	20% of AA after deductible	40% of AA after deductible	Requires pre-authorization. 6 months in a 3-year period maximum.

Medical Event	Services You May Need	Your Cost If You Use a Contracted Provider	Your Cost If You Use a Non-Contracted Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	40% of AA after deductible	One routine exam per plan year.
	Glasses	Full charge	Full charge	Not covered under this plan.
	Dental check-up	Full charge	Full charge	Not covered under this plan.

Excluded Services & Other Covered Services:

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

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Coverage provided outside the U.S.	• Routine eye care (Adults and children, exams only)
• Long-term care	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: www.pehp.org or 1-800-765-7347.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage. **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-765-7347.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-765-7347.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-765-7347.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-765-7347.]

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,032
- **Patient pays** $3,508

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$1,008
Limits or exclusions	$0
Total	**$3,508**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,320
- **Patient pays** $3,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$580
Limits or exclusions	$0
Total	**$3,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

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

Important Notices About Your Benefits

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

Notice of COBRA Rights

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

QUALIFIED BENEFICIARY

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

WHO IS COVERED

» Employees

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

» Spouse of Employees

If you are the spouse of an employee covered by PEHP, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose continuation coverage for yourself if you lose group health coverage under PEHP for any of the following reasons:

1. The death of your spouse;

2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse;

4. Your spouse becoming entitled to Medicare; or

5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

» Dependent children

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

1. The death of the covered parent;

2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment.

3. The parents' divorce or legal separation;

4. The covered parent becoming entitled to Medicare;

5. The Dependent ceasing to be a "Dependent child" under PEHP;

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

7. As defined by your employer.

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

SECONDARY EVENT

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

SEPARATE ELECTION

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

YOUR DUTIES UNDER THE LAW

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

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

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

EMPLOYER'S DUTIES UNDER THE LAW

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

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.

CONTINUATION COVERAGE MAY BE TERMINATED

The law provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following reasons:

1. Your Employer no longer provides group health coverage to any of its employees.

2. The premium for continuation coverage is not paid in a timely manner (within the applicable grace period).

3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation with respect to any preexisting condition of the individual.

4. The date in which the individual becomes entitled to Medicare, after the date of election.

5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.

6. Coverage will be terminated if determined by PEHP that the employee or family member has committed any of the following, fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage plus 2%.

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

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. More information regarding COBRA may be found in the PEHP Master Policy, and your Plan's Benefit Summary found at www.pehp.org.

QUESTIONS

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

Notice of Women's Health and Cancer Rights Act

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

1. All stages of reconstruction on the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Prostheses; and

4. Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable deductibles and copayment limitations consistent with those established for other benefits.

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

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

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

Notice of Newborns' and Mothers' Health Protection Act

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

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

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

Notice of Exemption from HIPAA

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

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

» The exemption from this Federal requirement will be in effect for the 2016-17 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.