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

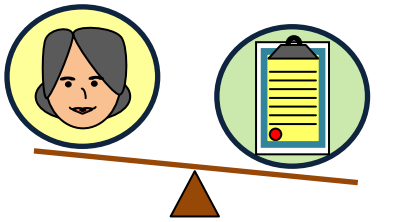
A request for your health insurer or plan to review a decision or a grievance again.

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

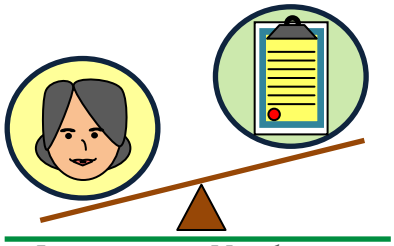
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.

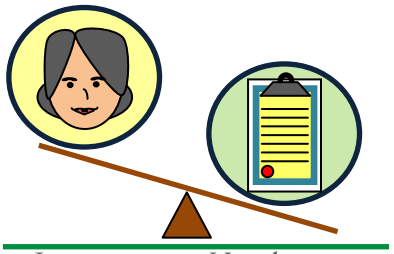
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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.

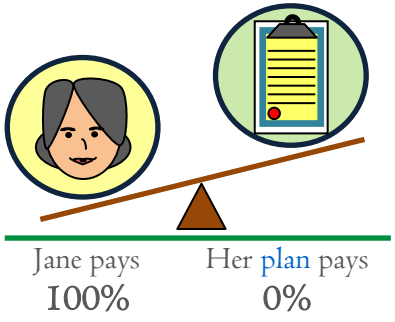
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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

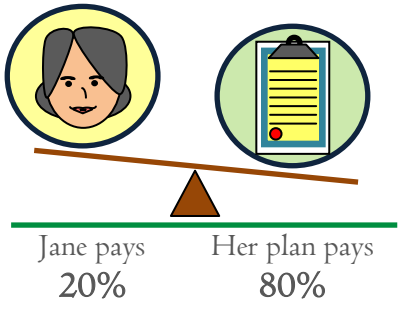


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

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

more costs

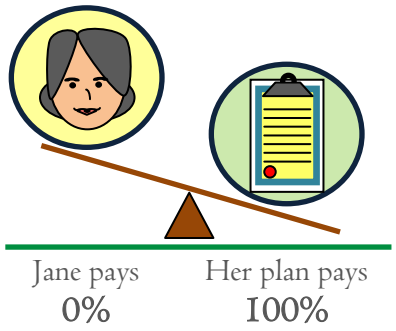


Jane reaches her $1,500 deductible, co-insurance begins

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Some network provider visits or preventive care received from network providers are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,000** person/**$10,000** family for network providers. No out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit PEHP e-Care: $10 co-pay per visit PEHP Value Clinics: $10 co-pay	40% of Allowed Amount (AA) after deductible	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	$35 co-pay/visit	40% of AA after deductible	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the allowed amount is under $350, 20% of AA after deductible if AA 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	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail, $25 minimum/$50 maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail, $50 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	$125 co-pay	$125 co-pay plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$45 co-pay	40% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*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	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$35 co-pay/visit	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.
	Inpatient services	20% of AA after deductible	Not covered	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge for skilled nursing visit	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible or $35 co-pay/visit	40% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	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.
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: $35 co-pay per visit.	40% of AA after deductible	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for network providers.
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Dental care (Adults or children)
- Developmental delay — testing and treatment
- 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
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications
- Weight-loss programs

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** $750
- **Specialist copayment** $35
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,120**

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

- **The plan's overall deductible** $750
- **Specialist copayment** $35
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$950
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

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

- **The plan's overall deductible** $750
- **Specialist copayment** $35
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

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

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

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

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	$150 co-pay	$150 co-pay plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$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	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$40 co-pay/visit	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.
	Inpatient services	20% of AA after deductible	Not covered	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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

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

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

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- 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
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications
- Weight-loss programs

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

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

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

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

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

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

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

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

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

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

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

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** single/**$5,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care received from network providers is not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,000** single/**$10,000** family for network providers. No out-of-pocket limit for out-of-network providers. Any one individual may not apply more than $7,150 toward the family out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% of Allowed Amount (AA) after deductible PEHP e-Care: $10 co-pay per visit after deductible PEHP Value Clinics: 20% of AA after deductible	40% of Allowed Amount (AA) after deductible	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible.
	Specialist visit	20% of AA after deductible	40% of AA after deductible	
	Preventive care/ screening/immunization	No charge	40% of AA after deductible	*Limited to the Preventive Plus list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% of AA after deductible	40% of AA after deductible	*Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. *Infertility services are payable at 50% of AA after deductible for eligible services. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	20% of AA after deductible	40% of AA after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay after deductible/ retail	The preferred co-pay after deductible plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost after deductible/retail, $25 minimum/$50 maximum	The preferred co-pay after deductible plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost after deductible/retail, $50 minimum/No maximum	The preferred co-pay after deductible plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Tier A 40% of AA after deductible Tier B 50% of AA after deductible	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	20% of AA after deductible	20% of AA after deductible, plus any balance billing	———None———
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	20% of AA after deductible	40% of AA after deductible	———None———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*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	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after deductible	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.
	Inpatient services	20% of AA after deductible	Not covered	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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

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

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

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Dental care (Adults or children)
- Developmental delay — testing and treatment
- 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
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications
- Weight-loss programs

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

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

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

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

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

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

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

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

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

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

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

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

PEHP Health & Benefits

STAR

Summit

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to out-of-pocket maximum*	$2,500 per single, $5,000 per family	
Plan year Out-of-Pocket Maximum *Any one individual may not apply more than $7,150 toward the In-Network family Out-of-Pocket Maximum*	$5,000 per single, $10,000 per family	
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Rehabilitation | *Up to 45 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will apply*	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible plus any balance billing above In-Network Rate
Urgent Care Facility	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *Outpatient – up to 20 combined visits per plan year. No Preauthorization required*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible

*You pay 20% of In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care *Amwell*	**Medical:** $10 co-pay per visit after deductible. **Mental Health:** Standard benefits apply after deductible. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	**Medical:** 20% of In-Network Rate after deductible	Not applicable
Primary Care Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	20% of In-Network Rate after deductible	Not covered
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible*		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No maximum	Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No maximum	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate. No maximum co-pay **Tier B:** 30% of In-Network Rate. No maximum co-pay	**Tier A:** 40% of In-Network Rate. No maximum co-pay **Tier B:** 50% of In-Network Rate. No maximum co-pay
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C:** 20%. No maximum co-pay	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	20% after deductible, plan pays up to $4,000 per adoption	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Up to 20 visits per plan year*	20% of In-Network Rate after deductible	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Infertility Services *Select services only. See Master Policy for details*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections *Requires preauthorization if over $750*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction *Up to $1,000 Lifetime Maximum*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible

PEHP Health & Benefits

Traditional Option 3

Summit

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *Applies to out-of-pocket maximum*	$750 per individual, $1,500 per family	
Plan year Out-of-Pocket Maximum**	$5,000 per individual, $10,000 per family	
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	No charge	40% of In-Network Rate after deductible
Rehabilitation | *Up to 45 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	$125 co-pay per visit	$125 co-pay per visit, plus any balance billing above In-Network Rate
Urgent Care Facility	$45 co-pay per visit	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *Outpatient – up to 20 combined visits per plan year. No Preauthorization required*	Applicable office co-pay per visit	40% of In-Network Rate after deductible

*You pay 20% of In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

**Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	Applicable office co-pay per visit	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care *Amwell*	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits and Office Surgeries	$25 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	$35 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	$35 co-pay per visit	$35 co-pay per visit, plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	**Outpatient:** Applicable office co-pay per visit. **Inpatient:** 20% of In-Network Rate after deductible	Not covered
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No maximum	Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No maximum	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 30% of In-Network Rate after deductible. No maximum co-pay	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C:** 20%. No maximum co-pay	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge, plan pays up to $4,000 per adoption	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Up to 20 visits per plan year*	Applicable office co-pay per visit	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	No charge	40% of In-Network Rate after deductible
Infertility Services** *Select services only. See Master Policy for details*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections *Requires preauthorization if over $750*	**Under $50:** No charge **Over $50:** 20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction** *Up to $1,000 Lifetime Maximum*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible

PEHP Health & Benefits

Traditional Option 4

Summit

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider***
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible *Applies to out-of-pocket maximum*	$1,000 per individual, $2,000 per family	
Plan year Out-of-Pocket Maximum**	$6,000 per individual, $12,000 per family	
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	No charge	40% of In-Network Rate after deductible
Rehabilitation | *Up to 45 days per plan year. Requires preauthorization*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	$150 co-pay per visit	$150 co-pay per visit, plus any balance billing above In-Network Rate
Urgent Care Facility	$50 co-pay per visit	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *Outpatient – up to 20 combined visits per plan year. No Preauthorization required*	Applicable office co-pay per visit	40% of In-Network Rate after deductible

*You pay 20% of In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum.

**Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	Applicable office co-pay per visit	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care *Amwell*	**Medical:** $10 co-pay per visit. **Mental Health:** Standard benefits apply. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Office Visits and Office Surgeries	$30 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	$40 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	$40 co-pay per visit	$40 co-pay per visit, plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor *For each test allowing $350 or less*	No charge	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major *For each test allowing more than $350*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service. Inpatient services require preauthorization*	**Outpatient:** Applicable office co-pay per visit. **Inpatient:** 20% of In-Network Rate after deductible	Not covered
PRESCRIPTION DRUGS		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / No maximum **Tier 3:** 50% of discounted cost, $50 minimum / No maximum	Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / No maximum **Tier 3:** 50% of discounted cost, $100 minimum / No maximum	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 30% of In-Network Rate after deductible. No maximum co-pay	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C:** 20%. No maximum co-pay	Not covered

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption | *See limitations*	No charge, plan pays up to $4,000 per adoption	
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care | *Up to 20 visits per plan year*	Applicable office co-pay per visit	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME *Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits*	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires preauthorization*	No charge	40% of In-Network Rate after deductible
Infertility Services** *Select services only. See Master Policy for details*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections *Requires preauthorization if over $750*	**Under $50:** No charge **Over $50:** 20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction** *Up to $1,000 Lifetime Maximum*	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible

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 2017-18 plan year. The election may be renewed for subsequent plan years.

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

Notice of Privacy Practices for Protected Health Information

effective August 31, 2013

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

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

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

Types of Personal Information PEHP collects

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

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

Understanding Your Health Record / Information

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

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

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

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

Your Health Information Rights

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

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

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

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.
- That occurred before April 14, 2003.

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

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

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

Examples of Uses and Disclosures of Protected Health Information

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

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

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

PEHP will use your health information for health operations.
For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess

the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. PEHP will only do so after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

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

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

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

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

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

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

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

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

Our Responsibilities Under the Federal Privacy Standard

PEHP is required to:

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

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

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

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

Inspecting Your Health Information

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

For More Information or to Report a Problem

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

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

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

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

IMPORTANT NOTICE FROM PEHP ABOUT PEHP's MEDICARE D DRUG PLANS

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

There are two important things you need to know about the PEHP prescription drug plans and Medicare's prescription drug coverage:

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter during Medicare open enrollment from October 15 to December 7. Coverage begins on January 1 for those enrolling during open enrollment.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a PEHP Medicare drug plan, or a Medicare Advantage Plan that includes a drug plan, your current Medicare Drug coverage may be affected in accordance with the Centers for Medicare and Medicaid Services (CMS). **The PEHP Medicare D drug plans provided by PEHP are creditable.**

If you decide to join a PEHP Medicare drug plan and drop your current prescription drug coverage, be aware that you and your eligible dependents may not be able to get this coverage back.

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

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

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

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

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

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

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

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

For More Information About Medicare Prescription Drug Coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

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

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

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