

# Glossary of Health Coverage and Medical Terms

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

## Allowed Amount

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

## Appeal

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

## Balance Billing

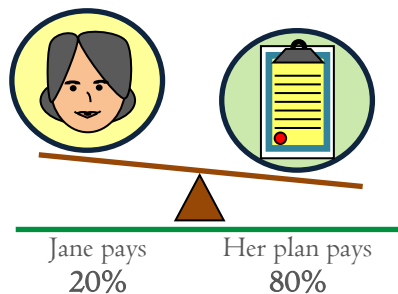
When a [provider](#) bills you for the balance remaining on the bill that is not covered by your [plan](#). This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill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

## Claim

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

## Coinsurance

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



## Complications of Pregnancy

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

## Copayment

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

## Cost Sharing

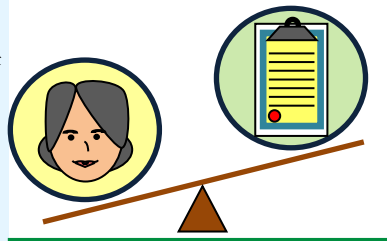
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for deductibles and out-of-pocket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

## Cost-sharing Reductions

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

## Deductible

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



Jane pays 100%      Her plan pays 0%  
(See page 6 for a detailed example.)

## Diagnostic Test

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

## Durable Medical Equipment (DME)

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

## Emergency Medical Condition

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

## Emergency Medical Transportation

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

## Emergency Room Care / Emergency Services

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

## Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

## Formulary

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

## Grievance

A complaint that you communicate to your health insurer or [plan](#).

## Habilitation Services

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

## Health Insurance

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

## Home Health Care

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

## Hospice Services

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

## Hospitalization

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

## Hospital Outpatient Care

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

## Individual Responsibility Requirement

Sometimes called the “individual mandate,” the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don’t have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

## In-network Coinsurance

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

## In-network Copayment

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

## Marketplace

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

## Maximum Out-of-Pocket Limit

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

## Medically Necessary

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

## Minimum Essential Coverage

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

## Minimum Value Standard

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

## Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

## Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a plan. You will pay less if you see a provider in the [network](#). Also called “preferred provider” or “participating provider.”

## Orthotics and Prosthetics

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

## Out-of-network Coinsurance

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

## Out-of-network Copayment

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

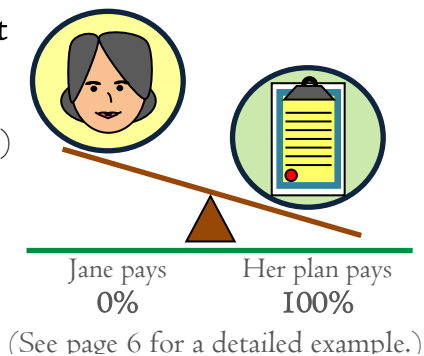
## Out-of-network Provider (Non-Preferred Provider)

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

## Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the [plan](#) will usually pay 100% of the

[allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some plans don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments or other expenses toward this limit.



## Physician Services

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

## Plan

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

## Preauthorization

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

## Premium

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

## Premium Tax Credits

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

## Prescription Drug Coverage

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

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Preventive Care

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

## Primary Care Physician

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

## Primary Care Provider

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

## Provider

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



## Reconstructive Surgery

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

## Referral

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

## Rehabilitation Services

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

## Screening

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

## Skilled Nursing Care

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

## Specialist

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

## Specialty Drug

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

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

## Urgent Care

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

# How You and Your Insurer Share Costs - Example

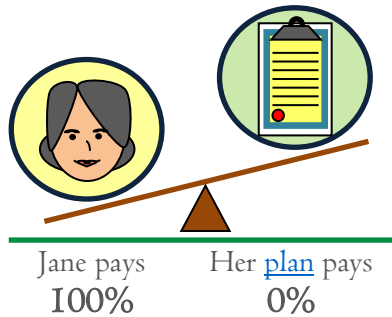
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Coverage Period

December 31<sup>st</sup>  
End of Coverage Period



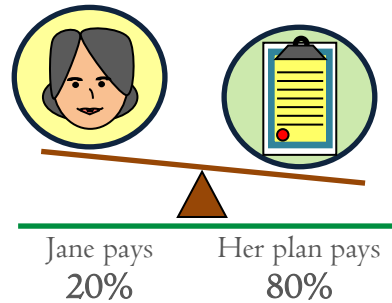
## Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



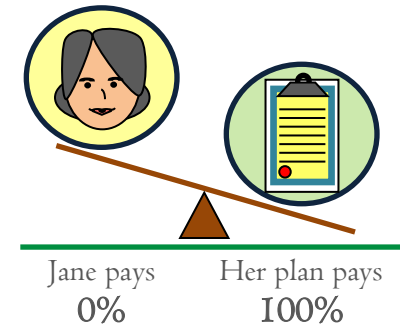
## Jane reaches her \$1,500 deductible, coinsurance begins

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

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



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

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

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.pehp.org](http://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](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

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



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 <u>provider's office</u> 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 <u>Allowed Amount</u> (AA) after <u>deductible</u>	*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 <u>Allowed Amount</u> (AA) after <u>deductible</u> .  *You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist visit</u>	\$35 co-pay/visit	40% of AA after <u>deductible</u>	
	<u>Preventive care/ screening/immunization</u>	No charge	40% of AA after <u>deductible</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge if the <u>Allowed Amount</u> (AA) is under \$350, 20% of AA after <u>deductible</u> if AA is over \$350	40% of AA after <u>deductible</u>	*Attended sleep studies, and any sleep studies done in a facility require <u>pre-authorization</u> and are limited to \$2,000 in a 3-year period.  *Infertility services are payable at 50% of AA after <u>deductible</u> for eligible services.  *Genetic testing requires <u>pre-authorization</u> .  *Some scans require <u>pre-authorization</u> .
	Imaging (CT/PET scans, MRIs)	No charge if the AA is under \$350, 20% of AA after <u>deductible</u> if AA is over \$350	40% of AA after <u>deductible</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> .	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 <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . 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.  *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail, \$25 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail, \$50 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	<u>Specialty drugs</u> (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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 <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after <u>deductible</u> when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires <u>pre-authorization</u> .
	Physician/surgeon fees	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 co-pay	\$125 co-pay plus any <u>balance billing</u>	---None---
	<u>Emergency medical transportation</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	*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.
	<u>Urgent care</u>	\$45 co-pay	40% of AA after <u>deductible</u>	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Take-home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .
	Physician/surgeon fee	\$25/\$35 co-pay per visit depending on <u>provider type</u> , 20% of AA after <u>deductible</u> for surgeons fees	40% of AA after <u>deductible</u>	
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 <u>deductible</u>	Not covered	
If you are pregnant	Office visits	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Childbirth/delivery facility services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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	<u>Home health care</u>	No charge for skilled nursing visit	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	20% of AA after <u>deductible</u> or \$35 co-pay/visit	40% of AA after <u>deductible</u>	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires <u>pre-authorization</u> 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 <u>pre-authorization</u> .
	<u>Habilitation services</u>	20% of AA after <u>deductible</u> or \$35 co-pay/visit	40% of AA after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment over \$750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require <u>pre-authorization</u> .
	Hospice service	No charge	40% of AA after <u>deductible</u>	----None----
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 <u>deductible</u>	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for <u>network providers</u> .
	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](http://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.)

- |  |  |  |  |   |
|--|--|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations</li><li>• Bariatric surgery</li><li>• Charges for which a third party, auto insurance, or worker's compensation plan are responsible</li><li>• Chiropractic care from an <u>out-of-network provider</u></li></ul> | <ul style="list-style-type: none"><li>• Complications from any non-covered services, devices, or medications</li><li>• Cosmetic surgery</li><li>• Custodial care and/or maintenance therapy</li><li>• Developmental delay — testing and treatment</li><li>• Foot care — routine</li><li>• Glasses</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• 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</li></ul> | <ul style="list-style-type: none"><li>• Mental health and substance abuse care from an <u>out-of-network provider</u> outside the U.S.</li><li>• Nursing — private duty</li><li>• Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines</li><li>• Office visits — in conjunction with hearing aids;</li></ul> | <ul style="list-style-type: none"><li>charges for after hours or holiday</li><li>• Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP</li><li>• Weight-loss programs</li></ul> |
|--|--|--|--|---|

### 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
- Dental care (Adults or children)
- 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](http://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](http://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](http://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:



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

■ <b>The plan's overall deductible</b>	\$750
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$7,600</b>
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In this example, Peg would pay:

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

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

■ <b>The plan's overall deductible</b>	\$750
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$5,500</b>
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In this example, Joe would pay:

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

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

■ <b>The plan's overall deductible</b>	\$750
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

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

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](http://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](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

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





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 <u>provider's office</u> 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 <u>Allowed Amount</u> (AA) after <u>deductible</u>	*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 <u>Allowed Amount</u> (AA) after <u>deductible</u> .  *You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist visit</u>	\$40 co-pay/visit	40% of AA after <u>deductible</u>	
	<u>Preventive care/ screening/immunization</u>	No charge	40% of AA after <u>deductible</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge if the <u>Allowed Amount</u> (AA) is under \$350, 20% of AA after <u>deductible</u> if AA is over \$350	40% of AA after <u>deductible</u>	*Attended sleep studies, and any sleep studies done in a facility require <u>pre-authorization</u> and are limited to \$2,000 in a 3-year period.  *Infertility services are payable at 50% of AA after <u>deductible</u> for eligible services.  *Genetic testing requires <u>pre-authorization</u> .  *Some scans require <u>pre-authorization</u> .
	Imaging (CT/PET scans, MRIs)	No charge if the AA is under \$350, 20% of AA after <u>deductible</u> if AA is over \$350	40% of AA after <u>deductible</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> .	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 <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . 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.  *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail, \$25 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail, \$50 minimum/No maximum	The preferred co-pay plus the difference above the discounted cost	
	<u>Specialty drugs</u> (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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 <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after <u>deductible</u> when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires <u>pre-authorization</u> .
	Physician/surgeon fees	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 co-pay	\$150 co-pay plus any <u>balance billing</u>	----None----
	<u>Emergency medical transportation</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	*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.
	<u>Urgent care</u>	\$50 co-pay	40% of AA after <u>deductible</u>	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Take-home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .
	Physician/surgeon fee	\$30/\$40 co-pay per visit depending on <u>provider type</u> , 20% of AA after <u>deductible</u> for surgeons fees	40% of AA after <u>deductible</u>	
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 <u>deductible</u>	Not covered	
If you are pregnant	Office visits	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Childbirth/delivery facility services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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	<u>Home health care</u>	No charge for skilled nursing visit	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	20% of AA after <u>deductible</u> or \$40 co-pay/visit	40% of AA after <u>deductible</u>	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires <u>pre-authorization</u> 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 <u>pre-authorization</u> .
	<u>Habilitation services</u>	20% of AA after <u>deductible</u> or \$40 co-pay/visit	40% of AA after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment over \$750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require <u>pre-authorization</u> .
	Hospice service	No charge	40% of AA after <u>deductible</u>	----None----
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: \$40 co-pay per visit.	40% of AA after <u>deductible</u>	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for <u>network providers</u> .
	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](http://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.)

- |  |  |  |  |   |
|--|--|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations</li><li>• Bariatric surgery</li><li>• Charges for which a third party, auto insurance, or worker's compensation plan are responsible</li><li>• Chiropractic care from an <u>out-of-network provider</u></li></ul> | <ul style="list-style-type: none"><li>• Complications from any non-covered services, devices, or medications</li><li>• Cosmetic surgery</li><li>• Custodial care and/or maintenance therapy</li><li>• Developmental delay — testing and treatment</li><li>• Foot care — routine</li><li>• Glasses</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• 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</li></ul> | <ul style="list-style-type: none"><li>• Mental health and substance abuse care from an <u>out-of-network provider</u> outside the U.S.</li><li>• Nursing — private duty</li><li>• Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines</li><li>• Office visits — in conjunction with hearing aids;</li></ul> | <ul style="list-style-type: none"><li>charges for after hours or holiday</li><li>• Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP</li><li>• Weight-loss programs</li></ul> |
|--|--|--|--|---|

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

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

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### Does this Coverage Provide Minimum Essential Coverage? **Yes.**

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

### Does this Coverage Meet the Minimum Value Standard? **Yes.**

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

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

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

■ <b>The plan's overall deductible</b>	\$1,000
■ <b>Specialist copayment</b>	\$40
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$7,600</b>
---------------------------	----------------

In this example, Peg would pay:

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

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

■ <b>The plan's overall deductible</b>	\$1,000
■ <b>Specialist copayment</b>	\$40
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$5,500</b>
---------------------------	----------------

In this example, Joe would pay:

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

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

■ <b>The plan's overall deductible</b>	\$1,000
■ <b>Specialist copayment</b>	\$40
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

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

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](http://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](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$2,500 single/\$5,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care received from <u>network providers</u> is not subject to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No	You do not have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000 single/\$10,000 family for <u>network providers</u> . No <u>out-of-pocket limit</u> for <u>out-of-network providers</u> . Any one individual may not apply more than \$7,900 toward the family <u>out-of-pocket limit</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and healthcare this <u>plan</u> doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.pehp.org">www.pehp.org</a> or call 1-800-765-7347 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your network <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>Allowed Amount (AA)</u> after <u>deductible</u>  PEHP e-Care: \$10 co-pay per visit after <u>deductible</u>  PEHP Value Clinics: 20% of AA after <u>deductible</u>	40% of <u>Allowed Amount (AA)</u> after <u>deductible</u>	*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 <u>Allowed Amount (AA)</u> after <u>deductible</u> .
	Specialist visit	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Preventive care/ screening/immunization	No charge	40% of AA after <u>deductible</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Attended sleep studies, and any sleep studies done in a facility require <u>pre-authorization</u> and are limited to \$2,000 in a 3-year period.
	Imaging (CT/PET scans, MRIs)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Infertility services are payable at 50% of AA after <u>deductible</u> for eligible services.  *Genetic testing requires <u>pre-authorization</u> .  *Some scans require <u>pre-authorization</u> .
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> .	Generic drugs (Tier 1)	\$10 co-pay after <u>deductible</u> /retail	The preferred co-pay after <u>deductible</u> 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 <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . 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 <u>deductible</u> /retail, \$25 minimum/No maximum	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost after <u>deductible</u> /retail, \$50 minimum/No maximum	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	<u>Specialty drugs</u> (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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 <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after <u>deductible</u> when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires <u>pre-authorization</u> .
	Physician/surgeon fees	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	----None----
	<u>Emergency medical transportation</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	*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.
	<u>Urgent care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Take-home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .
	Physician/surgeon fee	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after <u>deductible</u>	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 <u>deductible</u>	Not covered	
If you are pregnant	Office visits	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Childbirth/delivery facility services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://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	<u>Home health care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires <u>pre-authorization</u> 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 <u>pre-authorization</u> .
	<u>Habilitation services</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment over \$750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require <u>pre-authorization</u> .
	<u>Hospice service</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
If your child needs dental or eye care	Children's eye exam	No charge	40% of AA after <u>deductible</u>	*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](http://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.)

- |  |  |  |  |   |
|--|--|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations</li><li>• Bariatric surgery</li><li>• Charges for which a third party, auto insurance, or worker's compensation plan are responsible</li><li>• Chiropractic care from an <u>out-of-network provider</u></li></ul> | <ul style="list-style-type: none"><li>• Complications from any non-covered services, devices, or medications</li><li>• Cosmetic surgery</li><li>• Custodial care and/or maintenance therapy</li><li>• Developmental delay — testing and treatment</li><li>• Foot care — routine</li><li>• Glasses</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• 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</li></ul> | <ul style="list-style-type: none"><li>• Mental health and substance abuse care from an <u>out-of-network provider</u> outside the U.S.</li><li>• Nursing — private duty</li><li>• Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines</li><li>• Office visits — in conjunction with hearing aids;</li></ul> | <ul style="list-style-type: none"><li>charges for after hours or holiday</li><li>• Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP</li><li>• Weight-loss programs</li></ul> |
|--|--|--|--|---|

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

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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](http://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)

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$7,600</b>
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In this example, Peg would pay:

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

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

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$5,500</b>
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In this example, Joe would pay:

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

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

■ <b>The plan's overall deductible</b>	\$2,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	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*)

<b>Total Example Cost</b>	<b>\$2,500</b>
---------------------------	----------------

In this example, Mia would pay:

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

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.



**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](http://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](http://www.pehp.org). If you haven't created an online personal account, you'll need your PEHP ID and Social Security number. Find your PEHP ID number on your benefits card or your claims. Or call PEHP at 801-366-7555.

## Notice of COBRA Rights

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

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

### Qualified Beneficiary

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

### Who is Covered

#### » Employees

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

#### » Spouse of Employees

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

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

#### » Dependent Children

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

1. The death of the covered parent;
2. The termination of the covered parent's employment (for

reasons other than gross misconduct) or reduction in the covered parent's hours of employment;

3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under PEHP; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired.

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

### Secondary Qualifying Event

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

### Separate Election

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

### Your Duties Under The Law

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

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

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

## **Employers' Duties Under The Law**

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

## **Election of COBRA Coverage**

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

## **Premium Payments**

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

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

## **How Long Will Coverage Last?**

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

## **Special Rules For Disability**

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

### **The criteria that must be met for a disability extension is:**

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

## **Special Rules For Retirees**

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

## **COBRA Coverage May Be Terminated**

The law provides that your COBRA Coverage may be terminated prior to the expiration of the 18-, 29-, or 36-month period for *any* of the following reasons:

1. Your Employer no longer provides group health Coverage to any of its Employees.
2. The premium for COBRA Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.

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

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

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

### Questions

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

## Notice of Women's Health and Cancer Rights Act

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

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

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

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

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

## Notice of Newborns' and Mothers' Health Protection Act

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

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

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

## Notice of 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 2019-20 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 ABOUT YOUR EMPLOYER'S 2019 PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D PLANS**

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you 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. Your employer has determined the 2019 prescription drug coverage offered by your employer's plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing prescription drug coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a 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 first for those enrolling during open enrollment. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month special enrollment period (SEP) to 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 Medicare drug plan, your current prescription drug coverage through your employer may be affected in accordance with the Center for Medicare and Medicaid Services (CMS). **The 2019 prescription drug plans offered by your employer provided by PEHP are creditable.**

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

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

You should also know if you drop or lose your current prescription drug coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current prescription drug 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 prescription drug coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join a Medicare prescription drug plan.



## **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 801-366-7555. 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 may also request a copy of this notice at any time.

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

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

## **For More Information About Medicare Prescription Drug Coverage:**

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://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 prescription 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).