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

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

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

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

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

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

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

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

ON THE WEB
»myPEHP ........................................ www.pehp.org
myPEHP is your online source for personal health and plan benefit information. Review your claims history, see a comprehensive list of your coverages, look up in-network providers, check your FLEX$ account balance, and more. Create a myPEHP account to enroll in PEHP benefits electronically.

CUSTOMER SERVICE
.................................................. 801-366-7555
.................................................. or 800-765-7347
Weekdays from 8 a.m. to 5 p.m.
Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

PRE-NOTIFICATION/PRE-AUTHORIZATION
»Inpatient hospital pre-notification .......... 801-366-7755
.................................................. or 800-753-7754

MENTAL HEALTH/SUBSTANCE ABUSE
PRE-AUTHORIZATION
»PEHP Customer Service .................... 801-366-7555
.................................................. or 800-765-7347

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

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

SPECIALTY PHARMACY
»Accredo ................................. 800-501-7260

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

WELLNESS AND DISEASE MANAGEMENT
»PEHP Healthy Utah ....................... 801-366-7300
.................................................. or 855-366-7300
.................................................. www.healthyutah.org

»PEHP Waist Aweigh ....................... 801-366-7300
.................................................. or 855-366-7300
.................................................. www.pehp.org

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

»PEHP Integrated Care ..................... 801-366-7555
.................................................. or 800-765-7347
.................................................. www.pehp.org

VALUE-ADDED BENEFITS PROGRAM
»PEHPplus ..................................... www.pehp.org/plus

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

ONLINE ENROLLMENT HELP LINE
.................................................. 801-366-7410
.................................................. or 800-753-7410

CLAIMS MAILING ADDRESS
PEHP
560 East 200 South
Salt Lake City, UT 84102-2004
Benefit Changes

**Benefit Changes**

**Pre-existing Conditions**
Due to healthcare reform, Pre-existing Conditions can no longer be allowed for groups renewing on or after January 1, 2014. Any PEC waiting periods being currently applied to those affected members will be lifted upon the group’s renewal, and new hires for the groups renewing on or after that date will not be subject to any PEC waiting period.

**Combined Benefit Summary/Master Policy**
Beginning this plan year, the Master Policy will be combined with the Benefit Summary as one book. This allows all benefit information to be in one place and will continue to be available for members to access at www.pehp.org.

**Sleep Studies**
Facility sleep studies now require preauthorization. Home sleep studies do not require preauthorization.

**Dental Accidents**
Accidents that require dental services are now covered under the medical benefit.

**Administrative Changes**

**Paying the member out of network**
Beginning July 1, 2014, when a member has received services from a provider that does not hold any contract with PEHP in Utah, payment for those services will be paid directly to the member up to PEHP’s allowed amount. This will apply to any services from an out of network provider for medical, DME or lab services.

**Tax on HU rebates**
Beginning July 1, 2014 we will withhold FICA taxes for employees and pay the employer portion of FICA on all wellness cash rebates. To help members in filing their income taxes, we will include a W2 tax statement with the rebate check.

**Vision**
We will offer four vision options. Because you may get your vision exam under the medical plan, we will offer an eyewear-only plan, in which the rate will be less in exchange for no vision exam coverage. You may still choose the full vision plans if wish to get exams under your vision plan.

- EyeMed Full
- EyeMed Eyewear Only
- OptiCare Full
- OptiCare Eyewear Only

**FLEX$ Rollover**
You’ll be able to carryover up to $500 of unused FLEX$ money into the 2015-2016 plan year but will no longer have a grace period.

For the current (2013-2014) plan year, the FLEX$ grace period is still in effect. Your FLEX$ money for the 2013-2014 plan year must be used by the end of the grace period, September 15, 2014, or it will be forfeited.

(You can’t have a medical FLEX$ account if you’re contributing or receiving contributions to an HSA.)

**Autism Benefit**
Children older than 2 and younger than 7 who have been diagnosed with an autism spectrum disorder may be eligible for the Autism Treatment Program. This benefit will only be offered with The STAR Plan or Traditional plan. You won’t be eligible if you’re enrolled in Utah Basic Plus.

Eligibility will be determined based on a review of your medical records. PEHP will pay 80% after a $250 deductible specific to the autism benefit. The program pays a maximum of $150 per day not to exceed $24,000 total.

The Autism Treatment Program is not included in your medical benefits. None of its out-of-pocket expenses will accumulate toward your medical deductibles and out-of-pocket maximums.

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

Access Benefits and Claims at myPEHP

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

» See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.

» Get important plan documents, such as forms and Master Policies.

» Get a simple breakdown of the PEHP benefits in which you’re enrolled.

» Access your FLEX$ account.

» Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you’ll get an email every time a new one is available at myPEHP.

» Change your mailing address.

Find a Provider

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

Access Your Pharmacy Account

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

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

You’ll be able to:

» Check prices.

» Check an order status.

» Locate a pharmacy.

» Refill or renew a prescription.

» Get mail-order instructions.

» Print a temporary pharmacy card.

» Find detailed information specific to your plan, such as drug coverage, copayments, and cost-saving alternatives.
## PEHP Medical Networks

### PEHP Advantage

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

#### Participating Hospitals

<table>
<thead>
<tr>
<th>County</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaver County</td>
<td>Beaver Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Milford Valley Memorial Hospital</td>
</tr>
<tr>
<td>Box Elder County</td>
<td>Bear River Valley Hospital</td>
</tr>
<tr>
<td>Cache County</td>
<td>Logan Regional Hospital</td>
</tr>
<tr>
<td>Carbon County</td>
<td>Castleview Hospital</td>
</tr>
<tr>
<td>Davis County</td>
<td>Davis Hospital</td>
</tr>
<tr>
<td>Duchesne County</td>
<td>Uintah Basin Medical Center</td>
</tr>
<tr>
<td>Garfield County</td>
<td>Garfield Memorial Hospital</td>
</tr>
<tr>
<td>Grand County</td>
<td>Moab Regional Hospital</td>
</tr>
<tr>
<td>Iron County</td>
<td>Valley View Medical Center</td>
</tr>
<tr>
<td>Juab County</td>
<td>Central Valley Medical Center</td>
</tr>
<tr>
<td>Kane County</td>
<td>Kane County Hospital</td>
</tr>
<tr>
<td>Millard County</td>
<td>Delta Community Medical Center</td>
</tr>
<tr>
<td></td>
<td>Fillmore Community Hospital</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>Alta View Hospital</td>
</tr>
<tr>
<td></td>
<td>Intermountain Medical Center</td>
</tr>
<tr>
<td>Salt Lake County(cont.)</td>
<td>The Orthopedic Specialty Hospital (TOSH)</td>
</tr>
<tr>
<td></td>
<td>LDS Hospital</td>
</tr>
<tr>
<td></td>
<td>Primary Children’s Medical Center</td>
</tr>
<tr>
<td></td>
<td>Riverton Hospital</td>
</tr>
<tr>
<td>San Juan County</td>
<td>Blue Mountain Hospital</td>
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<tr>
<td></td>
<td>San Juan Hospital</td>
</tr>
<tr>
<td>Sanpete County</td>
<td>Gunnison Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Sanpete Valley Hospital</td>
</tr>
<tr>
<td>Sevier County</td>
<td>Sevier Valley Medical Center</td>
</tr>
<tr>
<td>Summit County</td>
<td>Park City Medical Center</td>
</tr>
<tr>
<td>Tooele County</td>
<td>Mountain West Medical Center</td>
</tr>
<tr>
<td>Uintah County</td>
<td>Ashley Valley Medical Center</td>
</tr>
<tr>
<td>Utah County</td>
<td>American Fork Hospital</td>
</tr>
<tr>
<td></td>
<td>Orem Community Hospital</td>
</tr>
<tr>
<td></td>
<td>Utah Valley Regional Medical Center</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>Heber Valley Medical Center</td>
</tr>
<tr>
<td>Washington County</td>
<td>Dixie Regional Medical Center</td>
</tr>
<tr>
<td>Weber County</td>
<td>McKay Dee Hospital</td>
</tr>
</tbody>
</table>

### PEHP Summit

The PEHP Summit network of contracted providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 39 participating hospitals and more than 7,500 participating providers.

#### Participating Hospitals

<table>
<thead>
<tr>
<th>County</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaver County</td>
<td>Beaver Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Milford Valley Memorial Hospital</td>
</tr>
<tr>
<td>Box Elder County</td>
<td>Bear River Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Brigham City Community Hospital</td>
</tr>
<tr>
<td>Cache County</td>
<td>Logan Regional Hospital</td>
</tr>
<tr>
<td>Carbon County</td>
<td>Castleview Hospital</td>
</tr>
<tr>
<td>Davis County</td>
<td>Lakeview Hospital</td>
</tr>
<tr>
<td></td>
<td>Davis Hospital</td>
</tr>
<tr>
<td>Duchesne County</td>
<td>Uintah Basin Medical Center</td>
</tr>
<tr>
<td>Garfield County</td>
<td>Garfield Memorial Hospital</td>
</tr>
<tr>
<td>Grand County</td>
<td>Moab Regional Hospital</td>
</tr>
<tr>
<td></td>
<td>Mountain West Medical Center</td>
</tr>
<tr>
<td>Juab County</td>
<td>Central Valley Medical Center</td>
</tr>
<tr>
<td>Kane County</td>
<td>Kane County Hospital</td>
</tr>
<tr>
<td>Millard County</td>
<td>Delta Community Medical Center</td>
</tr>
<tr>
<td></td>
<td>Fillmore Community Hospital</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>Huntsman Cancer Hospital</td>
</tr>
<tr>
<td></td>
<td>Jordan Valley Hospital</td>
</tr>
<tr>
<td>Salt Lake County(cont.)</td>
<td>Lone Peak Hospital</td>
</tr>
<tr>
<td></td>
<td>Pioneer Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Primary Children’s Medical Center</td>
</tr>
<tr>
<td></td>
<td>Riverton Children’s Unit</td>
</tr>
<tr>
<td></td>
<td>St. Marks Hospital</td>
</tr>
<tr>
<td></td>
<td>Salt Lake Regional Medical Center</td>
</tr>
<tr>
<td></td>
<td>University of Utah Hospital</td>
</tr>
<tr>
<td></td>
<td>University Orthopaedic Center</td>
</tr>
<tr>
<td>San Juan County</td>
<td>Blue Mountain Hospital</td>
</tr>
<tr>
<td></td>
<td>San Juan Hospital</td>
</tr>
<tr>
<td>Sanpete County</td>
<td>Gunnison Valley Hospital</td>
</tr>
<tr>
<td></td>
<td>Sanpete Valley Hospital</td>
</tr>
<tr>
<td>Sevier County</td>
<td>Sevier Valley Medical Center</td>
</tr>
<tr>
<td>Summit County</td>
<td>Park City Medical Center</td>
</tr>
<tr>
<td>Toodle County</td>
<td>Mountain West Medical Center</td>
</tr>
<tr>
<td>Uintah County</td>
<td>Ashley Valley Medical Center</td>
</tr>
<tr>
<td>Utah County</td>
<td>Mountain View Hospital</td>
</tr>
<tr>
<td></td>
<td>Timpanogos Regional Hospital</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>Heber Valley Medical Center</td>
</tr>
<tr>
<td>Washington County</td>
<td>Dixie Regional Medical Center</td>
</tr>
<tr>
<td>Weber County</td>
<td>Ogden Regional Medical Center</td>
</tr>
</tbody>
</table>

### PEHP Preferred

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

### Find Participating Providers

Go to www.pehp.org to look up participating providers for each plan.
Understanding Your Benefits Grid

**Plan Year Deductible**
The set dollar amount you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

**Plan Year Out-of-Pocket Maximum**
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for STAR plans). Some plans might also have separate out-of-pocket maximums for mental health & substance abuse and for specialty drug charges.

**Medical Deductible**
The set dollar amount you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

**Plan Year Out-of-Pocket Maximum**
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for STAR plans). Some plans might also have separate out-of-pocket maximums for mental health & substance abuse and for specialty drug charges.

**In-Network**
In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay any applicable co-payment.

**Out-of-Network**
If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP’s Allowed Amount.

**Allowed Amount (AA)**
The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the allowed amount (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

For more definitions, please see the Master Policy.
Understanding In-Network Providers

This year, Dixie State University plans pay limited benefits for out-of-network providers. It’s important to understand the difference between in-network and out-of-network providers and how the Allowed Amount works to avoid unexpected charges.

### Allowed Amount

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

### Balance Billing

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

### Negotiate a Price

DON’T GET BALANCE BILLED

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

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

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

### Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the comparison on Page 6 or go to www.pehp.org to see which network includes your doctors.

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

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

Go to www.pehp.org and click “Find a Provider” to find a doctor or facility in-network with your network.
Traditional (Non-HSA)

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

In-Network Provider

<table>
<thead>
<tr>
<th>Deductibles, Plan Maximums, and Limits</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible</td>
<td>$250 per individual, $500 per family</td>
<td>Same as using an in-network provider</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>$100 per individual, $200 per family</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Plan Year Out-of-Pocket Maximum***</td>
<td>$2,500 per individual, $5,000 per double, $7,500 per family</td>
<td>No Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>Pharmacy Out-of-Pocket Maximum</td>
<td>$3,000 per individual</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Specialty Drug Out-of-Pocket Maximum, office/outpatient</td>
<td>$3,600 per individual</td>
<td>No Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>Maximum Lifetime Benefit</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Applicable deductibles and coinsurance for services provided by an out-of-network provider will apply to your in-network plan year deductible and Out-of-Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, coinsurance amounts for out-of-network providers will still apply.

Inpatient Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network coinsurance</th>
<th>Out-of-Network coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
</tbody>
</table>

AA = Allowed Amount

***We track overall out-of-pocket spending to assure it doesn’t exceed the IRS-defined, overall out-of-pocket maximum. Please refer to the Master Policy for exceptions to the out-of-pocket maximum.

Out-of-Network providers may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 8.
### Outpatient Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility and Ambulatory Surgery</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Ambulance (ground or air)</td>
<td>20% of AA after deductible</td>
<td>20% of AA after deductible</td>
</tr>
<tr>
<td>Medical emergencies only, as determined by PEHP</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20% of AA, minimum $150 copayment per visit</td>
<td>20% of AA, minimum $150 copayment per visit</td>
</tr>
<tr>
<td>Medical emergencies only, as determined by PEHP</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$45 copayment per visit</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Preferred only:</td>
<td>University of Utah Medical Group Urgent Care Facility: $50 copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Minor</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>For each test allowing $350 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Major</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>For each test allowing more than $350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy, Radiation, and Dialysis</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Requires pre-authorization after 12 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>Applicable office copayment per visit</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Requires pre-authorization after 12 visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Professional Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Physician Visits</td>
<td>Applicable office copayment per visit</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Surgery and Anesthesia</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Primary Care Office Visits and Office Surgeries</td>
<td>$25 copayment per visit</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Preferred only:</td>
<td>University of Utah Medical Group Primary Care Office Visits: $50 copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visits and Office Surgeries</td>
<td>$35 copayment per visit</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>Preferred only:</td>
<td>University of Utah Medical Group Specialist Office Visit: $50 copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Specialist</td>
<td>$35 copayment per visit</td>
<td>$35 copayment per visit</td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Minor</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>For each test allowing $350 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Tests, X-rays, Major</td>
<td>20% of AA after deductible</td>
<td>40% of AA after deductible</td>
</tr>
<tr>
<td>For each test allowing more than $350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>Outpatient: $35 copayment per visit</td>
<td>Outpatient: 40% of AA after deductible</td>
</tr>
<tr>
<td>No pre-authorization required for outpatient services. Inpatient services require pre-authorization</td>
<td>Inpatient: Applicable office copayment per visit</td>
<td></td>
</tr>
</tbody>
</table>

**AA = Allowed Amount**

**Out-of-Network providers** may charge more than the AA unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 8.
### Prescription Drugs

<table>
<thead>
<tr>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
</table>
| **Retail Pharmacy** | **Preferred generic:** $10 copayment after deductible  
**Preferred brand name:** 25% of discounted cost after deductible.  
$25 minimum, no maximum copayment  
**Non-preferred:** 50% of discounted cost after deductible.  
$50 minimum, no maximum copayment | Plan pays up to the discounted cost, minus the applicable copayment.  
Member pays any balance |
| **Mail-Order** | **Preferred generic:** $20 copayment after deductible  
**Preferred brand name:** 25% of discounted cost after deductible.  
$50 minimum, no maximum copayment  
**Non-preferred:** 50% of discounted cost after deductible.  
$100 minimum, no maximum copayment | Plan pays up to the discounted cost, minus the applicable copayment.  
Member pays any balance |
| **Specialty Medications, retail pharmacy** | **Tier A:** 20% of AA after deductible.  
No maximum copayment  
**Tier B:** 30% of AA after deductible.  
No maximum copayment | Plan pays up to the discounted cost, minus the preferred copayment.  
Member pays any balance |
| **Specialty Medications, office/outpatient** | **Tier A:** 20% of AA after deductible.  
No maximum copayment  
**Tier B:** 30% of AA after deductible.  
No maximum copayment | 40% of AA after deductible |
| **Specialty Medications, through specialty vendor Accredo** | **Tier A:** 20% of AA after deductible.  
$150 maximum copayment  
**Tier B:** 30% of AA after deductible.  
$225 maximum copayment | Not covered |

### Miscellaneous Services

<table>
<thead>
<tr>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adoption</strong></td>
<td><strong>No charge after deductible, up to $4,000 per adoption</strong></td>
</tr>
</tbody>
</table>
| **Affordable Care Act Preventive Services**  
See Master Policy for complete list | **No charge** | 40% of AA after deductible |
| **Allergy Serum** | 20% of AA after deductible | 40% of AA after deductible |
| **Chiropractic Care**  
Up to 10 visits per plan year | Applicable office copayment per visit | 40% of AA after deductible |
| **Dental Accident** | 20% of AA after deductible | 40% of AA after deductible |
| **Durable Medical Equipment, DME**  
Except for oxygen and Sleep Disorder Equipment, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require pre-authorization. Maximum limits apply on many items. See the Master Policy for benefit limits | 20% of AA after deductible | 40% of AA after deductible |
| **Medical Supplies** | 20% of AA after deductible | 40% of AA after deductible |
| **Home Health/Skilled Nursing**  
Up to 60 visits per plan year  
Requires pre-authorization and Medical Case Management | 20% of AA after deductible | 40% of AA after deductible |
| **Infertility Services**  
Select services only. See the Master Policy | 50% of AA after deductible | 70% of AA after deductible |
| **Injections**  
Requires pre-authorization if over $750 | 20% of AA after deductible | 40% of AA after deductible |
| **Temporomandibular Joint Dysfunction**  
Up to $1,000 lifetime maximum | 50% of AA after deductible | 70% of AA after deductible |

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

**Out-of-Network providers** may charge more than the Allowed Amount unless they have an agreement with you not to. Any amount above the AA will be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 8.
Important Benefit Change After You Reach Your Out-of-Pocket Maximum

Total costs can vary for big-ticket healthcare procedures among Utah hospitals. Here’s an example generated by PEHP’s Cost Calculator.

Knee replacement - full

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Credit/Co-pay</th>
<th>TOTAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis Hospital; Jordan Valley Hospital; Pioneer Valley Hospital; Salt Lake Regional Hospital</td>
<td>$250 credit</td>
<td>$23,504</td>
</tr>
<tr>
<td>University of Utah Hospital</td>
<td>$100 co-pay</td>
<td>$33,016</td>
</tr>
<tr>
<td>St. Marks Hospital; Lakeview Hospital; Brigham City Community Hospital; Mountain View Hospital; Timpanogos Regional Hospital; Ogden Regional Medical Center</td>
<td>$500 co-pay</td>
<td>$33,739</td>
</tr>
<tr>
<td>“Hospital A”</td>
<td>“Hospital B”</td>
<td>“Hospital C”</td>
</tr>
</tbody>
</table>

Below is a list of credits and additional co-payments that apply for procedures listed on the next page for the Traditional (non-HSA) Plan on the Summit network.

Facility Name

- Davis Hospital; Jordan Valley Hospital; Pioneer Valley Hospital; Salt Lake Regional Hospital
- University of Utah Hospital
- St. Marks Hospital; Lakeview Hospital; Brigham City Community Hospital; Mountain View Hospital; Timpanogos Regional Hospital; Ogden Regional Medical Center

THESE APPLY ONLY WHEN YOU HAVE THE SUMMIT NETWORK

The hospitals below are part of the Summit network but have no credit or co-pay:

- Beaver County
  - Beaver Valley Hospital
  - Milford Valley Memorial Hospital
- Box Elder County
  - Bear River Valley Hospital
- Cache County
  - Logan Regional Hospital
- Carbon County
  - Castleview Hospital
- Duchesne County
  - Uintah Basin Medical Center
- Garfield County
  - Garfield Memorial Hospital
- Grand County
  - Moab Regional Hospital
- Iron County
  - Valley View Medical Center
- Juab County
  - Central Valley Medical Center
- Kane County
  - Kane County Hospital
- Millard County
  - Delta Community Medical Center
  - Fillmore Community Hospital
- Salt Lake County
  - Huntsman Cancer Hospital
  - Primary Children's Medical Center
  - River's Children's Unit
  - University Orthopaedic Center
- San Juan County
  - Blue Mountain Hospital
  - San Juan Hospital
- Sanpete County
  - Gunnison Valley Hospital
  - Sanpete Valley Hospital
- Sevier County
  - Sevier Valley Medical Center
- Summit County
  - Park City Medical Center
- Tooele County
  - Mountain West Medical Center
- Uintah County
  - Ashley Valley Medical Center
- Wasatch County
  - Heber Valley Medical Center
- Washington County
  - Dixie Regional Medical Center
Total costs can vary for big-ticket healthcare procedures among Utah hospitals. Here’s an example generated by PEHP’s Cost Calculator.

Knee replacement - full

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Credits/Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alta View Hospital</td>
<td>$100 credit</td>
</tr>
<tr>
<td>American Fork Hospital</td>
<td>$100 credit</td>
</tr>
<tr>
<td>Utah Valley Regional Medical Center</td>
<td>$100 credit</td>
</tr>
<tr>
<td>Orem Community Hospital</td>
<td>$100 credit</td>
</tr>
<tr>
<td>Davis Hospital</td>
<td>$200 co-pay</td>
</tr>
</tbody>
</table>

Below is a list of credits and additional co-payments that apply for procedures listed on the next page for the Traditional (non-HSA) Plan on the Advantage network.

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Credit/Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alta View Hospital</td>
<td>$100 credit (Your out-of-pocket maximum lowered by $100)</td>
</tr>
<tr>
<td>American Fork Hospital</td>
<td>$100 credit (Your out-of-pocket maximum lowered by $100)</td>
</tr>
<tr>
<td>Utah Valley Regional Medical Center</td>
<td>$100 credit (Your out-of-pocket maximum lowered by $100)</td>
</tr>
<tr>
<td>Orem Community Hospital</td>
<td>$100 credit (Your out-of-pocket maximum lowered by $100)</td>
</tr>
<tr>
<td>Davis Hospital</td>
<td>$200 co-pay (Your out-of-pocket maximum lowered by $100)</td>
</tr>
</tbody>
</table>

**THESE APPLY ONLY WHEN YOU HAVE THE ADVANTAGE NETWORK**

The hospitals below are part of the Advantage network but have no credit or co-pay:

- Beaver County: Beaver Valley Hospital, Milford Valley Memorial Hospital
- Box Elder County: Bear River Valley Hospital
- Cache County: Logan Regional Hospital
- Carbon County: Castleview Hospital
- Duchesne County: Uintah Basin Medical Center
- Garfield County: Garfield Memorial Hospital
- Grand County: Moab Regional Hospital
- Iron County: Valley View Medical Center
- Juab County: Central Valley Medical Center
- Kane County: Kane County Hospital
- Millard County: Delta Community Medical Center, Fillmore Community Hospital
- Salt Lake County: Intermountain Medical Center, The Orthopedic Specialty Hospital (TOSH), LDS Hospital, Primary Children’s Medical Center, Riverton Hospital
- San Juan County: Blue Mountain Hospital, San Juan Hospital
- Sanpete County: Gunnison Valley Hospital, Sanpete Valley Hospital
- Sevier County: Sevier Valley Medical Center
- Summit County: Park City Medical Center
- Tooele County: Mountain West Medical Center
- Uintah County: Ashley Valley Medical Center
- Wasatch County: Heber Valley Medical Center
- Washington County: Dixie Regional Medical Center
- Weber County: McKay-Dee Hospital
Applicable Procedures

**BACK**
Various spinal fusion surgeries
Back surgery (discectomy and laminectomy)

**BLADDER**
Bladder procedure, urinary incontinence repair

**COLON**
Colon surgery

**GALLBLADDER**
Gallbladder Removal, laparoscopic

**HEART**
Carotid endarterectomy
Valve replacement and repair
Heart bypass
Angioplasty

**HERNIA**
Hernia Repair, except inguinal and femoral for adults

**HIP**
Hip replacement

**HYSTERECTOMY**
Hysterectomy

**KNEE**
Knee replacement

**MASTECTOMY**
Total mastectomy for cancer

**PROSTATE**
Prostate Surgery (TURP)

**SHOULDER**
Shoulder replacement

**TUBAL**
Ovary/fallopian tube removal for cancer

Call PEHP to verify if your procedure is eligible for the credit/co-payment
Eligibility, Enrollment & Coordination of Benefits

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

General

Employees and their Dependents are eligible for Coverage as set forth herein. All Employees are required to enroll by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP’s online Enrollment portal. All information gathered and the information contained on the Enrollment form is incorporated into this contract. Any Enrollment or Coverage changes must be done in writing, by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP’s online Enrollment portal.

Eligibility

The eligibility of Employees and eligible Dependents is determined based on the Employer’s personnel policies and the Employee’s representations made on their verified individual Enrollment form, which form is a part of this contract. Copies of Member’s completed Enrollment forms are available upon request. Members who commit fraud or any other crime against PEHP are not eligible for Coverage.

Enrollment Period

You have 60 days from the date you become eligible for coverage to enroll you and your eligible dependents for coverage. The effective date of your coverage will be determined by your employer’s personnel policies.

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

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

Late Enrollees

Late enrollees are not eligible to enroll until the employer’s next annual enrollment period.

Special Enrollment

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

1) LOSS OF OTHER COVERAGE

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

1. The eligible Employee and/or their eligible Dependents declined to enroll in this Coverage due to the existence of other health plan Coverage; and

2. The eligible Employee and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 60 days after the date the other Coverage is lost.

Proof of loss of the other Coverage

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

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

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

c. A telephone call from the other Insurer to PEHP verifying dates of Coverage.
Eligibility, Enrollment & Coordination of Benefits

2) FAMILY STATUS CHANGE
PEHP shall also allow you and/or your Dependents to enroll if you gain an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time you enroll your Dependents, you may also be enrolled. In the case of birth or adoption of a child, you may also enroll your spouse, even though he/she is not newly eligible as a Dependent. However, special Enrollment is permitted only when the Enrollment takes place within 60 days of the marriage, birth, adoption or placement for adoption. PEHP must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in coverage. If a divorce decree is set aside by a court of competent jurisdiction, PEHP shall treat the Dependent(s) as eligible for re-Enrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.

3) LEGAL GUARDIANSHIP
You may enroll any unmarried, financially dependent children who are under age 19 that are placed under your or your spouse’s legal guardianship within 60 days of receiving such legal guardianship.

Transfer of Coverage
If you transfer from one PEHP plan to another, or if your coverage is terminated and then later reinstated, plan provisions for limited benefits, yearly maximum benefits, and lifetime limits will be maintained and be continuous from the point of transfer or termination.

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

1. Termination of employment – Coverage will terminate at the end of last day of work, the end of the last day of Employer’s payroll period or the end of the last day of the month, according to the Employer’s internal policies.

2. Dependent child turns age 26 – Coverage will terminate at the end of the day prior to the 26th birthday.

3. Dependent child (court-ordered guardianship or foster care) turns age 19 – Coverage will terminate at the end of the day prior to the 19th birthday.

4. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the day prior to the date on the court-signed divorce decree.

5. Death of Subscriber – Coverage will terminate at the end of last day of work, the end of the last day of Employer’s payroll period or the end of the last day of the month, according to the Employer’s internal policies.

6. Failure to make timely payment of rates to PEHP – Coverage will terminate at the end of the day through which previous payment has been received by PEHP.

7. Employer group terminates PEHP group coverage. The Subscriber may not terminate coverage for Dependents any time during the year unless one of the following conditions are met:
   a. Dependent enrolls in other group coverage;
   b. Commencement or termination of employment of Dependent;
   c. A change from part-time to full-time status (or vice versa) by the Subscriber or the Dependent; or
   d. A significant change in the health Coverage of the Subscriber, Subscriber’s spouse or Dependent attributable to their employment.

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

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

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

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

Liability for Services After Termination

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

Coordination of Benefits

COORDINATION OF BENEFITS WITH OTHER CARRIERS

The Coordination of Benefits provision applies when a Subscriber or the Subscriber's covered eligible Dependents have health care Coverage under more than one health benefit plan, except those specifically excluded in Section 3.6.6. Coordination of Benefits will be administered in accordance with Utah Insurance Code rules. When a Subscriber or Subscriber's covered Eligible Dependents have health Coverage under more than one benefit plan, one plan shall pay benefits as the primary plan and the other plan shall pay benefits as the secondary plan.

The Subscriber must inform PEHP of other medical Coverage in force by completing a Duplicate Coverage Inquiry Form. If applicable, the Subscriber will be required to submit court orders or decrees. Subscribers must also keep PEHP informed of any changes in the status of other Coverage.

COORDINATION OF BENEFITS RULES

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

COBRA Continuation Coverage

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

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

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

ACCEPTANCE OF BENEFITS AND NOTIFICATION
Acceptance of the benefits hereunder shall constitute acceptance of PEHP’s right to Subrogation rights as explained above. You are required to do the following:

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

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

Claims Submission

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

» When PEHP becomes the secondary payor, you are responsible to ensure timely filing from all providers. Claims must be submitted to PEHP within 15 months from the date of service to be eligible.

» When you provided incorrect information regarding medical plan coverage to an in-network provider.

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

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

Claims may be submitted electronically, or mailed to:

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

Requests for Information

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

REQUEST FOR INFORMATION BY A NON-SUBSCRIBER PARENT

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

Claims Appeal Process

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

Mail
PEHP Appeals and Policy Management Department
P.O. Box 3836
Salt Lake City, UT 84110-3836
Fax: 801-320-0541

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

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

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

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

**ACCIDENT, DENTAL**
A single unpremeditated event of violent or external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from the act of biting or chewing are not considered within the definition of an Accident.

**ACCIDENT, MEDICAL**
A single unpremeditated event of violent and external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from a willful action including lifting, pushing, pulling, bending, or straining are not considered within the definition of an Accident. Life-threatening conditions may not be considered within the meaning of an Accident.

**BALANCE BILL**
The dollar amount between the billed and Allowed Amount that the member is responsible to pay when services are received from an out-of-network provider.

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

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

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

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

**DEPENDENT**
“Dependent” means:

1. The Subscriber’s lawful spouse under Utah State Law. A valid marriage certificate and/or affidavit of marriage is required. A person of the opposite sex to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under Utah State Law. In Utah, you must obtain a court or administrative agency order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, PEHP will consider the change effective on the date the court or administrative order was signed by the court or administrative agency, or the date the order is received by PEHP, whichever is later.

2. Adult designee and their Dependents as defined by the Employer (if applicable).

3. Children or stepchildren of the Subscriber up to the age of 26 who have a Parental Relationship with the Subscriber. A valid birth certificate listing Subscriber or legal Spouse as parent is required.

4. Legally adopted children, who are adopted prior to turning 18 years old, foster children up to age 19, and children through legal guardianship up to the age of 19 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed.)

5. Children who are incapable of self support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber’s federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber’s Coverage continuing in effect. Periodic documentation is required. Subscriber must furnish written notification of the disability to PEHP no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning:

a. The condition that led to the Dependent’s physical or mental disability;

b. Income, if any, earned by the Dependent; and
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c. The capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities.

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

At the time of a Dependent’s approval for continued PEHP Coverage, PEHP shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent’s continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent’s Coverage will terminate on the renewal date.

6. When you or your lawful spouse are required by a court or administrative order to provide health coverage for a child, the child will be enrolled in your coverage according to PEHP guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions and will be subject to applicable PEC waiting period. The effective date for a qualified order will be the start date indicated in the order.

7. In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage but may be eligible to convert to a COBRA plan. PEHP will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree.

8. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under PEHP.

9. Dependent does not include an unborn fetus.

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

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

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

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

LIFE-THREATENING
The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Member’s life or cause permanent damage to the Member’s health such as, but not limited to, loss of heartbeat, loss of consciousness, limb-threatening, or organ-threatening cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life-threatening event will be made by PEHP on the basis of the final diagnosis and medical review of the records. PEHP reserves the right to solely determine whether or not a situation is Life-threatening.

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

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

PRE-AUTHORIZATION/PRIOR AUTHORIZATION
The process, prior to service, that the Member and the treating Provider must complete in order to obtain authorization for specified benefits of this Master Policy which may be subject to Limitations and to receive the maximum benefits of this Master Policy for Hospitalization, Surgical Procedures, Durable Medical Equipment, pharmaceutical drug products, or other services as required. Preauthorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted. Unless otherwise stated, preauthorizations are valid for 12 months from the date of the authorization, even if treatment has not been completed.

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

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

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

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

Notices

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

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

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

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

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

**Dependent Children**

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

1. The death of the covered parent;
2. The termination of the covered parent’s employment (for reasons other than gross misconduct) or reduction in the covered parent’s hours of employment.
3. The parents’ divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a “Dependent child” under PEHP;
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired; or
7. As defined by your employer.

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

**SECONDARY EVENT**

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

**SEPARATE ELECTION**

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

**YOUR DUTIES UNDER THE LAW**

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

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

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

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

**ELECTION OF CONTINUATION COVERAGE**
Members have 60 days from, either termination of coverage or date of receipt of COBRA election notice, to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again.

If you choose continuation coverage, your Employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

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

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

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

**SPECIAL RULES FOR DISABILITY**
If the employee or covered family member is disabled at any time during the first 60 days of COBRA continuation coverage, the continuation coverage period may be extended to 29 months for all family members, even those who are not disabled.

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

- Employee or family member must be determined by the Social Security Administration to be disabled.
- Must be determined disabled during the first 60 days of COBRA coverage.
- Employee or family member must notify PEHP of the disability no later that 60 days from the later of:
  - the date of the SSA disability determination; or
  - the date of the Qualifying Event, or
  - the loss of coverage date, or
  - the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.
- Employee or family member must notify employer within the original 18 month continuation period.
- If an employee or family member is disabled and another qualifying event occurs within the 29-month continuation period (other than bankruptcy of your Employer), then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

**SPECIAL RULE FOR RETIREES**
In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.
CONTINUATION COVERAGE MAY BE TERMINATED
The law provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following reasons:

1. Your Employer no longer provides group health coverage to any of its employees.
2. The premium for continuation coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see “Special rules for disability”) and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by PEHP that the employee or family member has committed any of the following, fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

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

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

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

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

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

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

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

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

All benefits are payable according to the schedule of benefits, based on this plan. Regular pre-authorization requirements apply.
Notice of Newborns’ and Mothers’ Health Protection Act

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

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

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

Notice of Exemption from HIPAA

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

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

The exemption from this Federal requirement will be in effect for the 2014-15 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.
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.

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.
Using Your Medical Benefits

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

Member Identification Card

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

In-Network Providers

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

Provider Directories

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

Out-of-Network Providers

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

Pre-notification and Pre-authorization

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

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

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

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

» All inpatient hospitalizations
» All skilled nursing facility admissions
» All inpatient hospital rehabilitation admissions

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

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

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

» Eligible dental procedures performed in an outpatient facility for patients 6 years of age and older
» Organ or tissue transplants
» Surgery that may be partially or wholly Cosmetic
» Coronary CT angiography
» Surgery performed in conjunction with obesity Surgery
» Implantation of artificial Devices
Using Your Medical Benefits

» New and Unproven technologies
» Cochlear implants
» Molecular diagnostics (genetic testing)
» Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days, except for sleep disorder equipment and oxygen
» Botox injections
» Maxillary/Mandibular bone or Calcitite augmentation Surgery
» All out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life-threatening
» Pelvic floor therapy
» Wound care, except for the diagnosis of burns
» Home health and Hospice Care
» Hyperbaric oxygen treatments
» Intrathecal pumps
» Spinal cord stimulators
» Surgical Procedures utilizing robotic assistance
» Implantable medications, excluding contraception
» Certain prescription and Specialty Drugs
» Continuous glucose monitoring Devices and supplies
» Jaw surgery
» Dialysis when using non-In-Network Providers
» Breast pumps – Hospital grade
» Human pasteurized milk
» Physical or occupational therapy after 12 combined visits
» Speech therapy after initial evaluation
» Stereotactic radiosurgery
» Magnetoencephalography (MEG)/ magnetic source imaging
» Voice therapy
» Breast reconstruction surgery
» Virtual colonoscopy

» Transanal endoscopic microsurgery
» Artificial ankle prosthetic
» Endovenous ablation therapy (Radiofrequency or laser)
» Manipulation under anesthesia
» Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation)
» Any Surgery for snoring
» Chelation therapy
» Video EEG Monitoring (VEEG)
» Insulin pumps
» Studies performed in a facility

Coverage Outside of Utah

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

**Urgent Care Condition**

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

Services to treat an urgent condition by an out-of-network provider in Utah will be allowed up to the Maximum Allowable fee and paid by PEHP at the amount specified for Out-of-Network Providers in the Members applicable benefit grid.

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

**Life-Threatening Emergencies in Utah**

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

**Life-Threatening Emergencies Outside of Utah**

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

**Emergency Transportation**

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

**Medical Case Management**

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

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

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

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

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

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

### Limitations

The following services are limited under your plan:

1. All eligible services performed by eligible providers are considered for payment up to PEHP’s maximum allowable fee.

2. When medically appropriate, PEHP Case Managers may approve the transfer of patients from an inpatient hospital setting to a transitional care unit or skilled nursing facility.

3. All services, including complications, for the following procedures will be covered at 50% of PEHP’s allowable fee:
   a. Breast reduction;
   b. Eligible testing and treatment for infertility;
   c. Blepharoplasty or other eyelid surgery;
   d. Spinal cord stimulators;
   e. All facility claims related to a hospital stay when the member is discharged against medical advice.

4. Payment for the following benefits will be limited to the dollar amount or visit limit shown below for the lifetime of your coverage with PEHP and will apply when a member terminates and reinstates coverage:
   a. Non-surgical treatment of TMJ/TMD – $1,000;
   b. Speech therapy – 60 visits.

5. Emergency care for life-threatening injury or illness caused by attempted suicide or anorexia/bulimia is covered as a medical benefit. Once the patient’s health is stabilized, further benefits will be payable at the inpatient mental health benefit level.

6. Organ or tissue donor charges for eligible transplants are not covered, except when the recipient is an eligible member covered under a PEHP plan. Laboratory typing/testing for organ transplants is eligible only when the recipient is an eligible member covered under a PEHP plan.

7. Multiple eligible surgical procedures performed during the same operative session are payable at 100% of the maximum allowable fee for the primary procedure and 50% for all additional procedures.

8. Dental services, including care and treatment of teeth and gums, orthodontia, periodontia, endodontia or prosthodontia are not covered, unless services are related to a dental accident and your plan includes coverage for dental accidents.

9. Physical and occupational therapy requires pre-authorization after 12 visits per plan year combined.

10. Only one medical, psychiatric, chiropractic, physical therapy, or osteopathic visit per day for the same diagnosis when billed by providers of the same specialty for any one member is allowable.

11. Speech therapy by a qualified speech therapist requires Pre-authorization. Eligible Benefits are limited to 60 visits per Member per lifetime. Therapy or evaluation provided by speech therapists for dysphagia (difficulty in swallowing) is payable separate from the speech therapy limit as a medical visit.

12. Predictive genetic counseling except in conjunction with the Affordable Care Act (Preventive Services under Section 6.14) or as Medically Necessary, as determined by PEHP.

13. Inpatient provider visits will be payable only in conjunction with authorized inpatient days.

14. Benefits for ground ambulance are payable only for medical emergencies and only to the nearest facility where proper care is available. Benefits for air ambulance are payable only for life-threatening emergencies when you could not be safely transported by ground ambulance and only to the nearest facility where proper medical care is available. If the emergency is not considered to be life-threatening by PEHP, air ambulance charges will be paid up to the
Medical Limitations and Exclusions

15. Skilled nursing visits may be approved up to a limit of 60 visits per plan year.

16. Hospice services may be approved for up to 6 months in a 3 year period.

17. Not all Durable Medical Equipment (DME) will be covered at plan benefits. Please refer to Appendix A of the PEHP Master Policy for a list of covered and non-covered equipment, as well as pre-authorization requirements. Any equipment not listed in Appendix A of the PEHP Master Policy requires pre-authorization.

18. Machine rental or purchase for the treatment of sleep disorders is payable at plan benefits, up to $2,500 in a five-year period, including all related equipment and supplies.

19. Artificial prosthetics, such as eyes or limbs, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Pre-authorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.

20. Wheelchairs require Pre-authorization through Medical Case Management. The maximum power wheelchair benefit available is one in any five-year period.

21. Reimbursement for knee braces is limited to one per knee in a three-year period.

22. Sleep studies performed at a facility for sleep disorders require Pre-authorization and are payable up to a maximum benefit of $2,000 in a three-year period.

23. Amounts paid for the following services will not apply to your out-of-pocket maximum*:
   a. Inpatient or outpatient mental health or substance abuse treatment for plans that do not have mental health parity or separate mental health substance abuse yearly out-of-pocket maximums;
   b. Temporomandibular Joint (TMJ/TMD/myofacial pain) treatment;
   c. Sleep apnea testing in a facility or sleep apnea equipment;
   d. Infertility testing or surgery;
   e. Surgeries or procedures payable at 50%;
   f. Adoption;
   g. Penalties for failing to obtain Pre-authorization or to complete Pre-notification;
   h. Supplies obtained through the pharmacy card;
   i. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
   j. Charges in excess of PEHP’s maximum allowable fee or contract limitations; or
   k. Charges for hospital services when the patient was discharged against medical advice (AMA).

24. PEHP will allow payment under the Medical Plan for Accidental injuries to sound, natural teeth occurring while a covered Member of PEHP, including their replacement. Sound, natural teeth are teeth that are whole or properly restored, are without impairment or periodontal disease and are not in need of treatment for reasons other than the dental injury. This benefit is available for a period not to exceed one year from the date of the Accident, and treatment must begin within 72 hours of the accident.

To be eligible for the Dental Accident benefit, the Accident must have occurred while a Member of PEHP. Coverage must also be continuous and in effect at time of service.

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

Exclusions

The following services are not covered under your plan:

1. All services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures or equipment related to non-covered services are not covered. When a non-covered service is performed as part of the same operation or process as a covered service, then only eligible charges relating to the covered service will be eligible for benefits.

2. Medical services, procedures, supplies or drugs used to treat secondary conditions or complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such complications include, but are not limited to:
   a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences as a result of non-covered or ineligible Surgery, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan;
   b. Complications as a result of a cosmetic surgery or procedure, except in cases of reconstructive surgery:
      1. When the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved party; or
      2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect; or
   c. Complications relating to services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than its FDA-Approved purpose.

3. Any care, treatment or procedure performed primarily for cosmetic purposes is not covered. Services are considered cosmetic when they are intended to improve appearance or correct a deformity without restoring physical bodily function. Cosmetic services that are not covered include, but are not limited to:
   a. Breast reconstructive surgery except as allowed under the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”). (See the WHCRA notice in this Benefits Summary for further information and limitations);
   b. Any reconstructive surgery, except those made necessary by an accidental injury occurring in the preceding 5 years;
   c. Rhinoplasty, except as a result of an accidental injury occurring in the preceding 5 years;
   d. Lipectomy, abdominoplasty, panniculectomy, unless any of these procedures are medically necessary to treat an unintended adverse event of an eligible surgery;
   e. Repair of diastasis recti;
   f. Hair transplants or other services to treat hair loss.

4. Treatment programs for enuresis or encopresis for Members age 18 and over.

5. Services or items primarily for convenience or other non-therapeutic purposes, such as: guest trays, personal hygiene items, home health aide and home nursing.

6. Services provided in a nursing home, rest home or a transitional living facility, community reintegration program, or vocational rehabilitation services to re-train self-care or activities of daily living (ADLs), including occupational therapy for activities of daily living (ADLs), academic learning, vocational or life skills or developmental delays.

7. Recreational therapy in any setting.

8. Biological serum, blood and blood plasma are not covered through the pharmacy card. Charges related to storing blood for future use.

9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.

10. Custodial care and/or maintenance therapy.

11. Take home medications.
Medical Limitations and Exclusions

12. Assisted reproductive technologies: invitro fertilization (IVF); gamete intra-fallopian tube transfer (GIFT); embryo transfer (ET); zygote intra fallopian transfer (ZIFT); pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman’s body. Any related services performed in conjunction with these procedures are also excluded.

13. Surgical treatment for correction of refractive errors.


15. All services related to gender dysphoria or gender identity disorder.

16. Sperm banking system, storage, treatment or other such services.

17. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by PEHP.

18. Any surgery solely for snoring.

19. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.

20. Treatment for sexual dysfunction.

21. Charges for physical examinations performed in connection with hearing aids.

22. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.

23. Epidemiological counseling and screening.


25. Hypnotherapy and biofeedback services.

26. Testing and treatment therapies for developmental delay or child development programs.

27. Cardiac rehabilitation, Phases 3 and 4.


29. Fitness programs.

30. Childbirth education classes.

31. The practice of using numerous procedure codes to identify procedures that normally are covered by a single code, known as “unbundling”.

32. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

33. Hospital leave of absence charges.

34. Service for milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.

35. Residential treatment programs.

36. Ambulance services for the convenience of the patient or family.

37. Private duty nursing, home health aide, custodial care and respite care.

38. Travel or transportation expenses, or escort services to provider’s offices or elsewhere.

39. The following adoption related expenses will not be covered:
   a. Expenses incurred from the adoption of nieces, nephews, brothers, sisters, grandchildren, cousins or stepchildren;
   b. Transportation, travel expenses or accommodations, passport fees, photos, postage, etc.;
   c. Living expenses, food and/or counseling for the birth mother.

40. Equipment purchased from non-licensed providers.

41. Used Durable Medical Equipment.

42. Charges for all services received as a result of an industrial claim (on-the-job) injury or illness, any portion of which, is payable under Worker’s Compensation or employer’s liability laws.

43. Charges that you are not, in absence of coverage, legally obligated to pay.
Medical Limitations and Exclusions

44. Charges for medical care rendered by an immediate family member are not covered. Immediate family members are spouses, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, stepparents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces and nephews, domestic partners, and adult designees.

45. Overutilization of medical benefits as determined by PEHP.

46. Charges that are not medically necessary to treat the condition, as determined by PEHP, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient’s illness or injury.

47. PEHP will not pay for charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which you are, or could be covered.

48. Charges for services as a result of an auto-related injury covered under No-fault insurance or that would have been covered if coverage were in effect as required by law.

49. Any service or supply not specifically identified as a benefit.

50. Services incurred in connection with injury or illness arising from the commission of:
   a. a felony;
   b. an assault, riot or breach of peace;
   c. a Class A misdemeanor;
   d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
   e. other illegal acts of violence.

51. Claims submitted past the timely filing limit as described in the applicable benefit summary.

52. Mastectomy for gynecomastia.

53. TENS units.

54. Neuromuscular stimulators.

55. H-wave electronic devices.

56. Sympathetic therapy stimulators.
Prescription Drug Coverage

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

**Prescription and Injectable Drug Benefits**

You will receive a member identification (ID) card upon enrollment. The ID card will only list the subscriber’s name, but will provide coverage for each enrolled family member. You only need to present your ID card or provide your ID number to a participating pharmacy along with an eligible prescription and any applicable copayment to receive your prescription medication.

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

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

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

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

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

**Participating Pharmacies**

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

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

Specialty and Injectable Drugs

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

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

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

Generic Substitution

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

Mail-Order Prescriptions

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

Examples of maintenance medications available through mail-order include:

- Diabetes medications
- Anticonvulsants
- Birth control pills
- Blood pressure drugs
- Asthma medications
- Antidepressants.

Examples of medications not available through mail-order include:

- Antibiotics
- Anti-anxiety
- Anti-migraine
- Injectables
- Pain medications
- Muscle relaxants.

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

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

Pharmacy Limitations and Exclusions

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

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

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

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

### PEHP Healthy Utah

PEHP Healthy Utah is an exclusive wellness benefit for subscribers and their spouses. It offers a variety of programs, services and resources to help you get and stay well - including cash rebates* for good health and health improvements.

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

**FOR MORE INFORMATION**

PEHP Healthy Utah  
801-366-7300 | 855-366-7300  
> E-mail: healthyutah@pehp.org  
> Web: www.healthyutah.org/myhu

### PEHP Waist Aweigh

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

For more information about PEHP Waist Aweigh and to enroll, go to www.pehp.org.

**FOR MORE INFORMATION**

PEHP Waist Aweigh  
801-366-7300 | 855-366-7300  
> E-mail: waistaweigh@pehp.org  
> Web: www.pehp.org

If you are unable to meet the medical standards to qualify for our weight management program and reach ongoing requirements, because it is unreasonably difficult due to a medical condition, upon written notification, PEHP will accept physician recommendation and/or modification to provide you with a reasonable alternative standard to participate. Members who claim PEHP Waist Aweigh rebates* are ineligible for the PEHP Healthy Utah BMI Improvement rebate*. The total amount of rewards cannot be more than 30% of the cost of employee-only coverage under the plan.

### PEHP WeeCare

PEHP WeeCare is our prenatal and postpartum program. The purpose of WeeCare is to help expectant mothers have a healthy pregnancy, a safe delivery, and a healthy baby. Those with PEHP coverage are eligible to participate.

Those eligible may enroll at any time during pregnancy through 12 weeks postpartum. WeeCare participants may qualify to receive free prenatal vitamins, educational materials, and cash rebates*.

**FOR MORE INFORMATION**

PEHP WeeCare  
P.O. Box 3503  
Salt Lake City, Utah 84110-3503  
801-366-7400 | 855-366-7400  
> E-mail: weecare@pehp.org  
> Web: www.pehp.org/weecare

### PEHP Plus

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

### Life Assistance Counseling

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

**FOR MORE INFORMATION**

Blomquist Hale, 800-926-9619  
> Web: www.blomquisthale.com

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*Effective July 1, 2014 FICA tax may be withheld from all wellness rebates. This will slightly lower any amount you receive. PEHP will mail additional tax information to you after you receive your rebate. Consult your tax advisor if you have any questions.
PEHP Dental Care

Introduction

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

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

There is no deductible for Diagnostic or Preventive services.

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

Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

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

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

Missing Tooth Exclusion

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

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

Limitations and Exclusions

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

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

Master Policy

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

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

Plan year deductible is $25 per member, up to a $75 maximum per family. Does not apply to preventive or diagnostic services.

Maximum Yearly Benefit per Member is $1,500.

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic Oral Examinations</td>
<td>No charge</td>
</tr>
<tr>
<td>Non-Specialist</td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td>20% of AA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanings and Fluoride Solutions</td>
<td>20% of AA</td>
</tr>
<tr>
<td>Sealants</td>
<td>Permanent molars only through age 17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restorative</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam Restoration</td>
<td>20% of AA after deductible</td>
</tr>
<tr>
<td>Composite Restoration</td>
<td>20% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endodontics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulpotomy</td>
<td>20% of AA after deductible</td>
</tr>
<tr>
<td>Root Canal</td>
<td>20% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Periodontics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td>Extractions</td>
<td>20% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anesthesia</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anesthesia</td>
<td>20% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthodontic Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-authorization may be required</td>
<td></td>
</tr>
<tr>
<td>Crowns</td>
<td>50% of AA after deductible</td>
</tr>
<tr>
<td>Bridges</td>
<td>50% of AA after deductible</td>
</tr>
<tr>
<td>Dentures (partial)</td>
<td>50% of AA after deductible</td>
</tr>
<tr>
<td>Dentures (full)</td>
<td>50% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All related services</td>
<td>50% of AA after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontic Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Lifetime Benefit per member is $1,500.</td>
<td></td>
</tr>
<tr>
<td>Eligible Appliances and Procedures</td>
<td>50% of eligible fees to plan maximum after deductible</td>
</tr>
</tbody>
</table>

AA = Allowed Amount
Save Money With FLEX$

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

FLEX$ Options

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

FLEX$ HEALTH CARE ACCOUNT

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

FLEX$ DEPENDENT DAY CARE ACCOUNT

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

Using Your FLEX$ Card

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

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

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

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

Important Considerations

» You must plan ahead wisely and set aside only what you will need for eligible expenses each year. FLEX$ is a use-it-or-lose-it program – only $500 will carry over from year to year.

» The total amount you elect to withhold throughout the year for medical expenses will be immediately available as soon as the plan year begins.

» You can’t contribute to a health savings account (HSA) while you’re enrolled in healthcare FLEX$. However, you may have a dependent day care FLEX$ or a limited FSA and contribute to an HSA.

Enrollment

ENROLL ONLINE

Log in to myPEHP at www.pehp.org.
Click on online enrollment.
Enroll today in a convenient and affordable vision care plan

You get vision wellness for you and your family
Regular eye exams measure your eyesight and they also can detect other serious illnesses such as diabetes, heart disease and high blood pressure.

You get great savings of approximately 40% with only a $10 eye exam copay
And, those who receive an annual eye exam with their medical plan also have a vision hardware choice. Save on eye exams, eyeglasses and contacts with vision coverage through your EyeMed plan.

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

Enroll today! For more information, see plan details on next page.
**PEHP Full (Plan H)**

### Vision Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam With Dilation as Necessary</strong></td>
<td>$10 Copay</td>
<td>Up to $30</td>
</tr>
<tr>
<td><strong>Contact Lens Fit and Follow-Up</strong></td>
<td>Up to $55</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-Up</td>
<td>10% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retinal Imaging</strong></td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>N/A</td>
<td>Up to $50</td>
</tr>
<tr>
<td>$0 Copay, $100 allowance, 20% off balance over $100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Standard Plastic Lenses

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>$10 Copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$10 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$75</td>
<td></td>
</tr>
<tr>
<td>Premium Progressive Lens</td>
<td>$95 - $120</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$95</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>$105</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>$120</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td>$75, 80% of charge less $120 allowance</td>
<td></td>
</tr>
</tbody>
</table>

### Lens Options

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>UV Treatment</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Polycarbonate—Adults</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Polycarbonate—Kids under 19</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td>$57 - $68</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$57</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$68</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 3</td>
<td>80% of charge</td>
<td>N/A</td>
</tr>
<tr>
<td>Photochromic/Transitions</td>
<td>$75</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Contact Lenses

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>$0 Copay, $120 Allowance, 85% off balance over $120</td>
<td>Up to $96</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 Copay, $120 Allowance, plus off balance over $120</td>
<td>Up to $96</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid in Full</td>
<td>Up to $200</td>
</tr>
</tbody>
</table>

### Laser Vision Correction

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASIK or PRK from U.S. Laser Network</td>
<td>15% off the retail price or 5% off the promotional price</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Additional Pairs Discount

Members also receive a 40% discount off complete pair of eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.

### Frequency

- **Exam** | Once every 12 months
- **Lenses or Contact Lenses** | Once every 12 months
- **Frame** | Once every 12 months

<table>
<thead>
<tr>
<th>Premiums (monthly)</th>
<th>Single</th>
<th>Double</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$753</td>
<td>$1234</td>
<td>$1713</td>
</tr>
</tbody>
</table>

---

*Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed’s Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.*

---

**Hello, Neighbor**

- • You’re on the INSIGHT Network
- • For more information on providers and services, please visit our Provider Locator on www.eyemed.com or call 1-800-886-0281.
- • For Lasik providers, call 1-877-5LASER6 or visit eyemedlasik.com.
**PEHP Eyewear Only (Plan F)**

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$75</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$95 - $120</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Premium Progressive Lensa</td>
<td>$95 - $120</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$95</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>$105</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>$120</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td>$75, 80% of charge less $120 allowance</td>
<td>Up to $40</td>
</tr>
</tbody>
</table>

**Lens Options** (paid by the member in addition to the price of the lenses)

- **UV Treatment**: $15 N/A
- **Tint (Solid and Gradient)**: $15 N/A
- **Standard Plastic Scratch Coating**: $15 N/A
- **Standard Polycarbonate—Adults**: $40 N/A
- **Standard Polycarbonate—Kids under 19**: $40 N/A
- **Standard Anti-Reflective Coating**: $45 N/A
- **Premium Anti-Reflective Coating**: $57 - $68 N/A
- **Tier 1**: $57 N/A
- **Tier 2**: $68 N/A
- **Tier 3**: 80% of charge N/A
- **Photochromic/Transitions**: $75 N/A
- **Polarized**: 20% off retail price N/A
- **Other Add-Ons and Services**: 20% off retail price N/A

**Contact Lenses** (Contact lens allowance includes materials only)

- **Conventional**: $0 Copay, $130 Allowance, 85% off balance over $130 Up to $104
- **Disposable**: $0 Copay, $130 Allowance, plus off balance over $130 Up to $104
- **Medically Necessary**: $0 Copay, Paid in Full Up to $200

**Laser Vision Correction**

- LASIK or PRK from U.S. Laser Network: 15% off the retail price or 5% off the promotonal price N/A

**Additional Pairs Discount**

Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.

**Frequency**

- Lenses or Contact Lenses: Once every 12 months
- Frame: Once every 12 months

**Premiums**—monthly

- **Single**: $6.49
- **Double**: $10.35
- **Family**: $14.21

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*Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed’s Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.*
It’s not about how much you can see, it’s about how well you can see.

Every eye is different and we don’t believe in cookie-cutter procedures. Custom LASIK provides wavefront scanning and custom mapping to give you a safer, more precise treatment that is as unique as your fingerprint.

SAVE $1,500 On Custom LASIK Surgery.

PEHP Opticare members save up to $750 per eye on custom LASIK vision correction surgery. LASIK surgery discount available at Standard Optical locations ONLY. All prescriptions welcome. Some restrictions apply. See store for details. Price may vary based on prescription. Financing available.
## Opticare Plan: 10-120C/120C

**PLAN OPTIONS:**

**10-120C Full Benefits** *(Eye exam and hardware benefit)*

**OR**

**120C Eyewear Only** *(No eye exam, hardware only benefit)*

### PEHP State of Utah

<table>
<thead>
<tr>
<th><strong>Select Network</strong></th>
<th><strong>Broad Network</strong></th>
<th><strong>Out-of-network</strong></th>
</tr>
</thead>
</table>

#### Eye Exam *(10-120C Plan ONLY)*

<table>
<thead>
<tr>
<th>Procedure</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass exam</td>
<td>$10 Co-pay</td>
<td>$15 Co-pay</td>
</tr>
<tr>
<td>Contact exam</td>
<td>$10 Co-pay</td>
<td>$15 Co-pay</td>
</tr>
<tr>
<td>Dilation</td>
<td>100% Covered</td>
<td>Retail</td>
</tr>
<tr>
<td>Contact Fitting</td>
<td>100% Covered</td>
<td>Retail</td>
</tr>
</tbody>
</table>

#### Plastic Lenses (10-120C/120C)

<table>
<thead>
<tr>
<th>Type</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>100% Covered</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Bifocal (FT 28)</td>
<td>100% Covered</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Trifocal (FT 7x28)</td>
<td>100% Covered</td>
<td>$10 Co-pay</td>
</tr>
</tbody>
</table>

#### Lens Options (10-120C/120C)

<table>
<thead>
<tr>
<th>Option</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Progressive (Standard plastic no-line)</em></td>
<td>$30 Co-pay</td>
<td>$50 Co-pay</td>
</tr>
<tr>
<td>*Premium Progressive Options</td>
<td>20% Discount</td>
<td>No Discount</td>
</tr>
<tr>
<td>*Glass lenses</td>
<td>15% Discount</td>
<td>15% Discount</td>
</tr>
<tr>
<td>Polycarbonate</td>
<td>$40 Co-pay</td>
<td>25% Discount</td>
</tr>
<tr>
<td>High Index</td>
<td>$80 Co-pay</td>
<td>25% Discount</td>
</tr>
</tbody>
</table>

#### Coatings (10-120C/120C)

<table>
<thead>
<tr>
<th>Coating</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scratch Resistant Coating</td>
<td>100% Covered</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Ultra Violet protection</td>
<td>100% Covered</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Other Options</td>
<td>Up to 25% Discount</td>
<td>Up to 25% Discount</td>
</tr>
<tr>
<td>A/R, edge polish, tints, mirrors, etc.</td>
<td>Discount</td>
<td>Discount</td>
</tr>
</tbody>
</table>

#### Frames (10-120C/120C)

<table>
<thead>
<tr>
<th>Frame Allowance</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$120 Allowance</td>
<td>$100 Allowance</td>
<td>$80 Allowance</td>
</tr>
</tbody>
</table>

#### Add'l Eyewear (10-120C/120C)

**Additional Pairs of Glasses**

<table>
<thead>
<tr>
<th>Frame Allowance</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 50% Off Retail</td>
<td>$120 Allowance</td>
<td>$100 Allowance</td>
</tr>
<tr>
<td>Up to 25% Off Retail</td>
<td>$120 Allowance</td>
<td>$100 Allowance</td>
</tr>
</tbody>
</table>

#### Contacts (10-120C/120C)

<table>
<thead>
<tr>
<th>Contact Allowance</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>$120 Allowance</td>
<td>$100 Allowance</td>
<td>$80 Allowance</td>
</tr>
</tbody>
</table>

#### Frequency (10/120C/120C)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams, Lenses, Frames, Contacts</td>
<td>Every 12 months</td>
<td>Every 12 months</td>
</tr>
</tbody>
</table>

#### LASIK Benefit (10-120C/120C)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>10-120C</th>
<th>120C</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASIK</td>
<td>$750 Off Per Eye</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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

**Discounts**

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

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

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

**LASIK services are not an insured benefit – this is a discount only.

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

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

For more Information please visit [www.opticareofutah.com](http://www.opticareofutah.com) or call 800-363-0950
Life Assistance Counseling

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

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

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

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

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

Licensed Professional Clinicians
100% Confidential
Convenient Locations

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