Lehi City
Group Health Plan

Annual Required Legal Notices and Disclosures for Plan Participants

List of Notices and Disclosures

HIPAA Notice of Privacy Practices

HIPAA Special Enrollment Notice

Women's Health and Cancer Rights Act Notice

Medicare Part D Notice of Creditable Rx Coverage

Model Wellness Program Notice/Disclosure

Medical Carrier Summary of Benefits and Coverage (SBC)

If you want additional information on any of these notices or the benefits they address, contact David Kitchen, HR Manager at (385) 201-2265 or dkitchen@lehi-ut.gov.

HIPAA Notice of Privacy Practices – Effective July 1, 2018

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Effective date of this Privacy Notice is: July 1, 2018

If you have questions or want to file a complaint, contact:

David Kitchen, HR Manager
dkitchen@lehi-ut.gov (385) 201-2265

Your Rights

You have the right to:

- Get a copy of and/or correct your health and claims record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Fundraising efforts
- Marketing purposes
- Sale of your information

Our Uses and Disclosures

We may use and share your information as we:

- Run our organization
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 3.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission.

- Marketing Purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Run our organization

- We can use and share your health information to run our organization and contact you when necessary.
- *We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We give information about you with your medical plan to coordinate payment for medical services.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Continued…

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

HIPAA Notice of Privacy Practices

Our Responsibilities.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

HIPAA Special Enrollment Notice

This notice explains your right to enroll in or make changes to your group health insurance coverage during the plan year.

Loss of Other Coverage
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage), except as specified below for Medicaid or CHIP coverage.

Marriage, Birth or Adoption
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP Coverage
If you or your dependents become eligible to participate in a Medicaid or Children's Health Insurance Plan (CHIP) premium assistance program, you may enroll for coverage under our health plan if you notify the plan administrator within 60 days after you become eligible to participate in Medicaid or CHIP.

If you or your dependents lose coverage under a Medicaid or CHIP premium assistance program due to loss of eligibility, you may enroll in our health plan if you apply to enroll within sixty (60) days of the loss of coverage under Medicaid or CHIP. If you enroll within sixty (60) days, the effective date of coverage is the first day after your Medicaid or CHIP coverage ended.

To request special enrollment or obtain more information, contact the Plan Administrator at (385) 201-2265 or dkitchen@lehi-ut.gov.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, co-payments and coinsurance applicable to other medical and surgical benefits provided under this plan. See the Summary Plan Description (SPD) or Benefits Summary.

Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or excluded from coverage by your plan.

For additional information on WHCRA benefits, contact the Plan Administrator at (385) 201-2265 or dkitchen@lehi-ut.gov.

Medicare Part D Notice of Creditable Coverage

Important Notice from Lehi City About Your Prescription Drug Coverage and Medicare

If you or your dependents are not eligible for Medicare, you may disregard this notice.

This notice applies to those covered under the Lehi City Benefit Plan. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with our Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Lehi City coverage will not be affected. Medicare eligible individuals who become eligible for Medicare Part D can keep this coverage if they elect Part D and this plan will pay primary to Medicare Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage under our plan, be aware that you and your dependents will not be able to get back this coverage back except at the next annual open enrollment or if you have a "special enrollment" event.

Medicare Part D Notice of Creditable Coverage

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Lehi City and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person at the number listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lehi City Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	July 1, 2018
Name of Entity/Sender:	Lehi City
Contact--Position/Office:	David Kitchen, HR Manager
Email Address:	dkitchen@lehi-ut.gov
Phone Number:	(385) 201-2265

lehiwellness

PHYSICAL · FINANCIAL · EMOTIONAL · COMMUNITY · CAREER · SOCIAL

Summary: Lehi City values your health and overall wellbeing and has partnered with PEHP to provide a confidential health and wellness program for full-time benefited employees.

Our **points-based wellness program** provides opportunities for employees to engage in healthy activities. Lehi City has adopted six components of wellness to optimize total health and wellbeing: **Career, Community, Emotional, Financial, Physical, and Social**.

Each component has multiple options for you to improve your overall health in a fun and interactive way. All information regarding the wellness program is available on the Infinity HR website at www.infinityhr.com, including a list of approved wellness activities.

Participation: Employees who elect medical coverage through PEHP and participate in Lehi City's Wellness Program during 2018-2019 Plan Year are eligible to receive a *5% premium advantage for the 2019-2020 Plan Year.* Those who choose NOT to participate in the wellness program will not receive the *premium advantage* and will pay the standard employee portion of medical premium (5%). Employees who have waived medical coverage through the City's plan will also be eligible to participate in activities, offerings, incentives/prizes through the wellness program; however, they will not be required to complete the HRA and biometric screening and will not be eligible for PEHP rebates.

Requirements: To receive the premium advantage for the 2019-2020 Plan Year, employees will need to complete **12 Wellness Points by April 30, 2019**, including a biometric screening and Health Risk Assessment. A full description of all wellness points is available at www.infinityhr.com .

Tracking: Wellness Points will be recorded by employees, participating partners, or HR for City-sponsored activities.

Our aim is to allow everyone options to succeed and to achieve even more benefits by working past the minimum requirements of 12 points. Apply the six aspects of well-being to optimize this program and work to create a fun, rewarding way to improve your overall health.

Best of Health
Lehi City Wellness Team

Rewards for participating in the wellness program are available to all full-time employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Pam Stagg at 385-201-2263 or pstagg@lehi-ut.gov to learn about the alternate options available for you.

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Some network provider visits or preventive care received from network providers are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,600** person/**$7,200** family for network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit PEHP e-Care: $10 co-pay per visit PEHP Value Clinics: $10 co-pay	Not covered	*The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. Infertility charges are payable at 50% of Allowed Amount (AA) after deductible.
	Specialist visit	$40 co-pay/visit	Not covered	
	Preventive care/ screening/immunization	No charge	Not covered	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the allowed amount is under $350, 20% of AA after deductible if AA is over $350	Not covered	*Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period. *Infertility services are payable at 50% of AA after deductible for eligible services. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	No charge if the allowed amount is under $350, 20% of AA after deductible if AA is over $350	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pehp.org.	Generic drugs (Tier 1)	$10 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	$25 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	$50 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs	Not covered	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	Not covered	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$150 co-pay	$150 co-pay plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$40 co-pay	Not covered	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	Not covered	*Take-home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	$30/$40 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$30 co-pay/visit	Not covered	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after deductible	Not covered	
If you are pregnant	Office visits	20% of AA after deductible	Not covered	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after deductible	Not covered	
	Childbirth/delivery facility services	20% of AA after deductible	Not covered	

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% of AA after deductible	Not covered	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	Inpatient: 20% of AA after deductible Outpatient: $40 co-pay/visit	Not covered	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	Inpatient: 20% of AA after deductible Outpatient: $40 co-pay/visit	Not covered	
	Skilled nursing care	20% of AA after deductible	Not covered	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	Not covered	*Sleep disorder equipment is limited to $325 in a plan year. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equip-ment or unlicensed providers of equipment.
	Hospice service	20% of AA after deductible	Not covered	*Requires pre-authorization. 6 months in a 3-year period maximum.
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: $40 co-pay per visit.	Not covered	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for network providers.
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

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

Excluded Services & Other Covered Services:

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

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

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

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

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

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

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

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

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

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** single/**$4,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care received from network providers is not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000** single/**$6,000** family for network providers. No out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	40% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Payable at 50% of AA after deductible when medically necessary: breast reduction; blepharoplasty; eligible infertility surgery; sclerotherapy of varicose veins; microphlebectomy. Spinal cord stimulators requires pre-authorization.
	Physician/surgeon fees	20% of AA after deductible	40% of AA after deductible	
If you need immediate medical attention	Emergency room care	20% of AA after deductible	20% of AA after deductible, plus any balance billing	---None---
	Emergency medical transportation	20% of AA after deductible	20% of AA after deductible, plus any balance billing	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	20% of AA after deductible	40% of AA after deductible	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	40% of AA after deductible	*Take-home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	20% of AA after deductible	40% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after deductible	40% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances, residential treatment programs. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after deductible	40% of AA after deductible	
If you are pregnant	Office visits	20% of AA after deductible	40% of AA after deductible	*Mother and baby's charges are separate. Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% of AA after deductible	40% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	40% of AA after deductible	

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	20% of AA after deductible	40% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization.
	Habilitation services	20% of AA after deductible	40% of AA after deductible	
	Skilled nursing care	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	Durable medical equipment	20% of AA after deductible	40% of AA after deductible	*Sleep disorder equipment is limited to $325 in a plan year. Equipment over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. No coverage for used equip-ment or unlicensed providers of equipment.
	Hospice service	20% of AA after deductible	40% of AA after deductible	*Requires pre-authorization. 6 months in a 3-year period maximum.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	*One routine exam per plan.
	Children's glasses	Not covered	Not covered	———None———
	Children's dental check-up	Not covered	Not covered	———None———

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

Excluded Services & Other Covered Services:

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

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

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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(9 months of in-network pre-natal care and a hospital delivery)

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Other coinsurance	20%

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,120
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,120**

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

The plan's overall deductible	$2,000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,700**

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

The plan's overall deductible	$2,000
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

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