



FAMILY CITY USA

2023 Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at ampeterson@orem.org or 801-229-7196.

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure

Employers must provide a notice to all employees when they first enroll in an employer-sponsored health plan and annually thereafter. This notice must describe the benefits that must be provided by the employer's medical benefits plans as required by WHCRA. In general, health plans providing coverage for mastectomies also must provide certain services relating to the mastectomy that are consistent with other benefits under the medical benefits plan.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 prescription drug plan.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Covered under the employer-sponsored medical plan, and
- 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 and coinsurance applicable to other medical and surgical benefits provided under this plan. Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

“HIPAA Special Enrollment Opportunities” include:

- COBRA (or state continuation coverage) exhaustion.
- Loss of other coverage ⁽¹⁾.
- Acquisition of a new spouse or dependent through marriage ⁽¹⁾, adoption ⁽¹⁾, placement for adoption ⁽¹⁾ or birth ⁽¹⁾.
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families)(60-day notice) ⁽¹⁾.
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-daynotice).

“Change in Status” Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.
- Examples of permitted “change in status” events include:
 - Change in legal marital status (e.g., marriage ⁽²⁾, divorce or legal separation)
 - Change in number of dependents (e.g., birth ⁽²⁾, adoption ⁽²⁾ or death)
 - Change in eligibility of a child
 - Change in your / your spouse’s / your state registered / unregistered / state registered and unregistered domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
 - A substantial change in your / your spouse’s / your state registered / unregistered / state registered and unregistered domestic partner’s benefits coverage
 - A relocation that impacts network access
 - Enrollment in state-based insurance Exchange
 - Medicare Part A or B enrollment
 - Qualified Medical Child Support Order or other judicial decree
 - A dependent’s eligibility ceases resulting in a loss of coverage ⁽³⁾
 - Loss of other coverage
 - Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
 - You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan Will Use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or

similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

1) Indicates that this event is also a qualified "Change in Status"

2) Indicates this event is also a HIPAA Special Enrollment Right

3) Indicates that this event is also a COBRA Qualifying Event

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on How Health Care Reform Affects Your Plan

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness ⁽¹⁾; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. ⁽¹⁾

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

1) The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

2) Special hours of service eligibility requirements apply to airline flight crew employees.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (2), and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 www.wagehour.dol.gov.

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You Do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

We will not provide advance notice to you when your continuation coverage terminates.

Reporting to Work/Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
181 days or more	Submit an application for reemployment within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service.	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service.	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definition

For you to be entitled to continued coverage under USERRA, your absence from work must be due to “service in the uniformed services.”

- “Uniformed services” means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
- “Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).



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 <u>deductible</u> ?	\$1,500 person/\$3,000 family for <u>network providers</u> . \$2,250 person/\$4,500 family for <u>out-of-network providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Some <u>network provider</u> visits or preventive care received from <u>network providers</u> are not subject to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You do not have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,500 person/\$9,000 family for <u>network providers</u> . \$6,000 person/\$12,000 family for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 co-pay/visit PEHP e-Care: \$10 co-pay per visit PEHP Value Clinics: \$10 co-pay	50% of Allowed Amount (AA) after deductible	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay. *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. *Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Specialist visit	\$50 co-pay/visit	50% of AA after deductible	
	Preventive care/screening/immunization	No charge	50% of AA after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	No charge if the Allowed Amount (AA) is under \$350, 20% of AA after deductible if AA is over \$350	50% of AA after deductible	*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. *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.
	Imaging (CT/PET scans, MRIs)	No charge if the AA is under \$350, 20% of AA after deductible if AA is over \$350	50% 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)	\$15 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Preferred brand drugs (Tier 2)	\$30 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	\$65 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	Tier A 40% of AA after deductible Tier B 50% 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after deductible	50% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require pre-authorization. ----None----
	Physician/surgeon fees	20% of AA after deductible	50% of AA after deductible	
	Emergency room care	\$225 co-pay after deductible/visit	\$225 co-pay after deductible/visit plus any balance billing	
If you need immediate medical attention	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. ----None----
	Urgent care	\$60 co-pay/visit	50% of AA after deductible/visit	
	Facility fee (e.g., hospital room)	20% of AA after deductible	50% of AA after deductible	
If you have a hospital stay	Physician/surgeon fee	\$40/\$50 co-pay per visit depending on provider type, 20% of AA after deductible for surgeons fees	50% 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. *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 require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling. ----None----
	Outpatient services	\$50 co-pay/visit	Not covered	
	Inpatient services	20% of AA after deductible	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Office visits	20% of AA after deductible	50% of AA after deductible	----None----
	Childbirth/delivery professional services	20% of AA after deductible	50% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	50% 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	<u>Home health care</u>	No charge for skilled nursing visit	50% of AA after deductible	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	Inpatient: 20% of AA after deductible. Outpatient: \$50 co-pay/visit	50% of AA after deductible	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires <u>pre-authorization</u> .
	<u>Habilitation services</u>	Inpatient: 20% of AA after deductible. Outpatient: \$50 co-pay/visit	50% of AA after deductible	
	<u>Skilled nursing care</u>	20% of AA after deductible	50% of AA after deductible	*Requires <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 days per plan year.
If your child needs dental or eye care	<u>Durable medical equipment</u>	20% of AA after deductible	50% of AA after deductible	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires <u>pre-authorization</u> .
	<u>Hospice service</u>	No charge	50% of AA after deductible	----None----
	Children's eye exam	Over age 5 and adults: \$50 co-pay per visit.	50% of AA after deductible	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for <u>network providers</u> .
	Children's glasses	Not covered	Not covered	----None----
	Children's dental check-up	Not covered	Not covered	----None----

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Developmental delay — screening
- 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
- Mental health and substance abuse care from an out-of-network provider
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids;
- 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
- Dental care (Adults or children)
- Routine eye care (Adults and children, exams only)

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

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

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

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

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

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

Language Access Services:

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

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

About these Coverage Examples:



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

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

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$50
- **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
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In this example, Peg would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,220
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$2,720

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

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$50
- **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
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In this example, Joe would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,300

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

- **The plan's overall deductible** \$1,500
- **Specialist copayment** \$50
- **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
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In this example, Mia would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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 <u>deductible</u> ?	\$3,000 individual/\$6,000 family for <u>network providers</u> . \$3,250 individual/\$6,500 family for <u>out-of-network providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care received from <u>network providers</u> is not subject to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You do not have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,500 individual/\$9,000 family for <u>network providers</u> . \$6,000 individual/\$12,000 family for <u>out-of-pocket limit</u> for <u>out-of-network providers</u> . Any one individual may not apply more than \$4,500 toward the <u>in-network family out-of-pocket limit</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and healthcare this <u>plan</u> doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% of <u>Allowed Amount (AA)</u> after <u>deductible</u> PEHP e-Care: \$10 co-pay per visit after <u>deductible</u> PEHP Value Clinics: 20% of AA after <u>deductible</u>	50% of <u>Allowed Amount (AA)</u> after <u>deductible</u>	*The following services are not covered: charges for after hours or holiday; acupuncture; testing and treatment for developmental delay. *Limited to the Preventive Plus list of preventive services.
	Specialist visit	20% of AA after <u>deductible</u>	50% of AA after <u>deductible</u>	
	Preventive care/ screening/immunization	No charge	50% of AA after <u>deductible</u>	
If you have a test	Diagnostic test (x-ray, blood work)	20% of AA after <u>deductible</u>	50% of AA after <u>deductible</u>	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires <u>pre-authorization</u> . *Some scans require <u>pre-authorization</u> .
	Imaging (CT/PET scans, MRIs)	20% of AA after <u>deductible</u>	50% of AA after <u>deductible</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pehp.org .	Generic drugs (Tier 1)	\$15 co-pay after <u>deductible</u> / retail	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or 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. *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.
	Preferred brand drugs (Tier 2)	\$30 co-pay after <u>deductible</u> / retail	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	\$65 co-pay after <u>deductible</u> / retail	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	

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

 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	50% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators requires pre-authorization. ----None----
	Physician/surgeon fees	20% of AA after deductible	50% of AA after deductible	
	Emergency room care	20% of AA after deductible/visit	20% of AA after deductible/visit plus any balance billing	
If you need immediate medical attention	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. ----None----
	Urgent care	20% of AA after deductible/visit	50% of AA after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after deductible	50% 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. *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 require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling. ----None----
	Physician/surgeon fee	20% of AA after deductible	50% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after deductible	50% of AA after deductible	
	Inpatient services	20% of AA after deductible	50% of AA after deductible	
If you are pregnant	Office visits	20% of AA after deductible	50% of AA after deductible	----None----
	Childbirth/delivery professional services	20% of AA after deductible	50% of AA after deductible	
	Childbirth/delivery facility services	20% of AA after deductible	50% 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	<u>Home health care</u>	20% of AA after deductible	50% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	20% of AA after deductible	50% 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.
	<u>Habilitation services</u>	20% of AA after deductible	50% of AA after deductible	
	<u>Skilled nursing care</u>	20% of AA after deductible	50% of AA after deductible	*Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after deductible	50% of AA after deductible	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires pre-authorization.
If your child needs dental or eye care	<u>Hospice service</u>	20% of AA after deductible	50% of AA after deductible	
	Children's eye exam	No charge	50% of AA after deductible	*One routine exam per plan year.
	Children's glasses	Not covered	Not covered	----None----
	Children's dental check-up	Not covered	Not covered	----None----

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

Excluded Services & Other Covered Services:

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

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

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

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

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.

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

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

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

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

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** \$3,000
- **Specialist copayment** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$7,600
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In this example, Peg would pay:

Cost sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$920
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,920

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

- **The plan's overall deductible** \$3,000
- **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
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In this example, Joe would pay:

Cost sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,500

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

- **The plan's overall deductible** \$3,000
- **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
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In this example, Mia would pay:

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

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

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