PEHP

Utah School Boards Association

2015-16

USBA Benefits Summary

UTAH SCHOOL BOARDS ASSOCIATION
Benefits Summary

Effective July 2015

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

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

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

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

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

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

8-7-15

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Medical Benefits

Wellness and Value-Added Benefits

Welcome to PEHP

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

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

ON THE WEB

» myPEHP . . . . . www.pehp.org
myPEHP is your online source for personal health and plan benefit information. You can review your claims history, see a comprehensive list of your coverages, look up in-network providers, check your FLEX$ account, and more.

CUSTOMER SERVICE

. 801-366-7555
. . . . . or 800-765-7347

Weekdays from 8 a.m. to 5 p.m.
Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

PRE-NOTIFICATION/PREAUTHORIZATION

» Inpatient Hospital Pre-notification. 801-366-7755
. . . . . or 800-753-7754

MENTAL HEALTH/SUBSTANCE ABUSE PREAUTHORIZATION

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

PRESCRIPTION DRUG BENEFITS

» PEHP Prescription Customer Service . . 801-366-7551
. . . . . or 888-366-7551

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

SPECIALTY PHARMACY

» Accredo 800-501-7260

WELLNESS AND DISEASE MANAGEMENT

» PEHP Healthy Utah 801-366-7300
. . . . . or 855-366-7300
. . . . . .www.healthyutah.org

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

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

PRENATAL PROGRAM

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

CLAIMS MAILING ADDRESS

PEHP
560 East 200 South
Salt Lake City, Utah 84102-2004

PEHP Online Tools

Access Benefits and Claims Online

Access important benefit tools and information by creating an online personal account at www.pehp.org.

- » Receive important messages about your benefits and coverage through our Message Center.
- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.
- » Become a savvy consumer using our Cost & Quality Tools.
- » View and print plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Track your biometric results and access Healthy Utah rebates and resources.
- » Access your FLEX$ account.
- » Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you'll get an email every time a new one is available.
- » Change your mailing address.

Find a Provider

Looking for a provider, clinic, or facility that is in-network with your plan? Look no farther than **www.pehp.org**. Go online to search for providers by name, specialty, or location.

Some PEHP plans pay benefits for out-of-network providers. However, PEHP doesn't pay for any services from certain providers, regardless if you have an out-of network benefit. Visit **www.pehp.org** to see those providers.

Access Your Pharmacy Account

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

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

You'll be able to:

- » Check prices.
- » Check an order status.
- » Locate a pharmacy.
- » Refill or renew a prescription.
- » Get mail-order instructions.
- » Find detailed information specific to your plan, such as drug coverage, copayments, and cost-saving alternatives.

Benefits Changes and Reminders

Pharmacy Benefit Changes

» **Specialty Rx**
› Specialty Pharmacy costs now apply to the medical out-of-pocket maximum.
› A new Tier C has been added to the Specialty Pharmacy Accredo benefit. This is an effort to help better manage your Specialty Pharmacy.

What's New

» **New PEHP Treatment Advisor**
This innovative online tool saves you the hassle of scouring the web for information related to your symptoms. Get information based on your personal treatment preferences and priorities. Compare treatments based on clinical evidence and others' experiences.

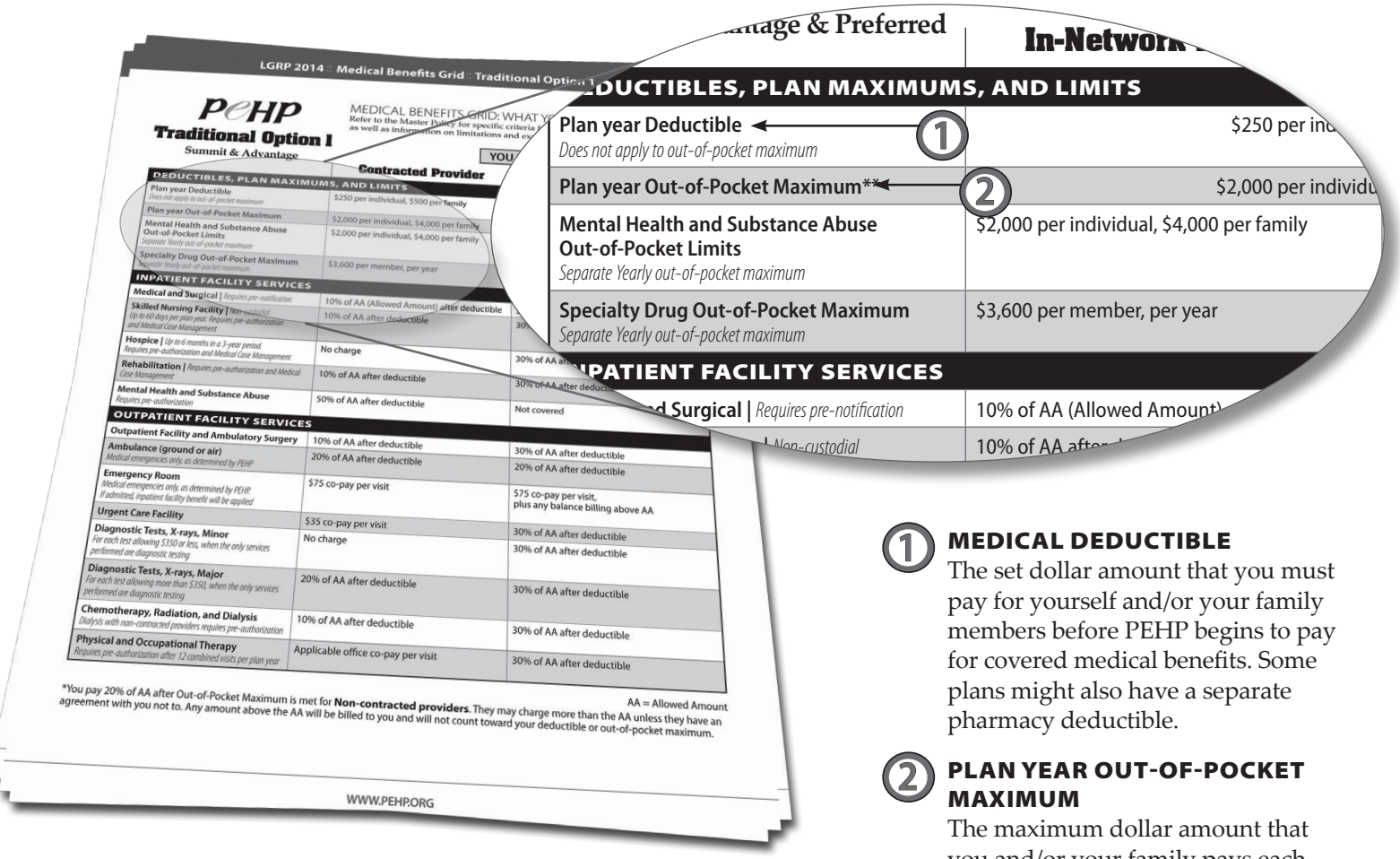
Reminders

» You can now shop for healthcare value, compare prices among providers, and save money using PEHP's new Cost & Quality Tools, accessible at myPEHP.

» In and out of network deductibles are combined and accumulate together on all USBA plans. In and out of network out-of-pocket maximums are combined and accumulate together on all USBA plans.

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

Understanding Your Benefits Grid



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

2 PLAN YEAR OUT-OF-POCKET MAXIMUM
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance.

CO-PAY
A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP In-Network Rate.

IN-NETWORK
In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay the applicable copayment.

OUT-OF-NETWORK
If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP's In-Network Rate.

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

For more definitions, please see the Master Policy.

Understanding In-Network Providers

It's important to understand the difference between in-network and out-of-network providers and how the In-Network Rate works to avoid unexpected charges.

In-Network Rate

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

Balance Billing

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

Negotiate a Price

DON'T GET BALANCE BILLED

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

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

The amount you pay for charges above the In-Network Rate won't apply to your deductible or out-of-pocket maximum.

Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the comparison on Page 8 or go to www.pehp.org to see which network includes your doctors.

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

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

PEHP Medical Networks

PEHP Advantage

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

PARTICIPATING HOSPITALS

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital

Cache County
- Logan Regional Hospital

Carbon County
- Castleview Hospital

Davis County
- Davis Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Valley View Medical Center

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Medical Center
- Fillmore Community Hospital

Salt Lake County
- Alta View Hospital
- Intermountain Medical Center

Salt Lake County (cont.)
- The Orthopedic Specialty Hospital (TOSH)
- LDS Hospital
- Primary Children's Medical Center
- Riverton Hospital

San Juan County
- Blue Mountain Hospital
- San Juan Hospital

Sanpete County
- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County
- Sevier Valley Medical Center

Summit County
- Park City Medical Center

Tooele County
- Mountain West Medical Center

Uintah County
- Ashley Valley Medical Center

Utah County
- American Fork Hospital
- Orem Community Hospital
- Utah Valley Regional Medical Center

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- McKay-Dee Hospital

PEHP Preferred

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

PEHP Summit

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

PARTICIPATING HOSPITALS

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital
- Brigham City Community Hospital

Cache County
- Logan Regional Hospital

Carbon County
- Castleview Hospital

Davis County
- Lakeview Hospital
- Davis Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Valley View Medical Center

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Medical Center
- Fillmore Community Hospital

Salt Lake County
- Huntsman Cancer Hospital
- Jordan Valley Hospital

Salt Lake County (cont.)
- Lone Peak Hospital
- Pioneer Valley Hospital
- Primary Children's Medical Center
- Riverton Children's Unit
- St. Marks Hospital
- Salt Lake Regional Medical Center
- University of Utah Hospital
- University Orthopaedic Center

San Juan County
- Blue Mountain Hospital
- San Juan Hospital

Sanpete County
- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County
- Sevier Valley Medical Center

Summit County
- Park City Medical Center

Tooele County
- Mountain West Medical Center

Uintah County
- Ashley Valley Medical Center

Utah County
- Mountain View Hospital
- Timpanogos Regional Hospital
- Mountain Point Medical (opens soon)

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- Ogden Regional Medical Center

Find Participating Providers

Go to www.pehp.org to look up participating providers for each plan.

Gold Plan » MEDICAL BENEFITS GRID

SUMMIT ADVANTAGE PREFERRED

Refer to the applicable Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	None	$500 per individual, $1,000 per family
Plan year Out-of-Pocket Maximum*	$3,500 per individual, $7,000 per family	$7,500 per individual, $15,000 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	10% of In-Network Rate after $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	10% of In-Network Rate after $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	10% of In-Network Rate	40% of In-Network Rate after Deductible
Rehabilitation | *Requires preauthorization*	10% of In-Network Rate after $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate	40% of In-Network Rate after Deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	10% of In-Network Rate after $250 Copayment	40% of In-Network Rate after Deductible and $250 Copayment per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	10% of In-Network Rate	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	10% of In-Network Rate after $150 Copayment	10% of In-Network Rate after $150 Copayment, plus any balance billing above In-Network Rate
Urgent Care Facility	No charge after $30 Copayment	40% of In-Network Rate after Deductible
Diagnostic Tests, X-rays	10% of In-Network Rate	40% of In-Network Rate after Deductible
Chemotherapy, Radiation, and Dialysis	10% of In-Network Rate	40% of In-Network Rate after Deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *20 visits per plan year.*	No charge after applicable Copayment per visit	40% of In-Network Rate after Deductible

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

	In-Network Provider	Out-of-Network Provider
PROFESSIONAL SERVICES		
Inpatient Physician Visits	10% of In-Network Rate	40% of In-Network Rate after Deductible
Surgery and Anesthesia	10% of In-Network Rate	40% of In-Network Rate after Deductible
Primary Care Office Visits *Includes office surgeries*	No charge after $20 Copayment per visit	40% of In-Network Rate after Deductible
Specialist Office Visits *Includes office surgeries*	No charge after $40 Copayment per visit	40% of In-Network Rate after Deductible
Emergency Room Specialist Visits	10% of In-Network Rate	10% of In-Network Rate, plus any balance billing above In-Network Rate
University of Utah Medical Group Office Visits *Preferred plan only. Includes office surgeries*	No charge after $40 Copayment per visit	Not applicable
Diagnostic Tests, X-rays	10% of In-Network Rate	40% of In-Network Rate after Deductible
Mental Health/Substance Abuse *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 20% of In-Network Rate **Outpatient:** 20% of In-Network Rate, up to 20 visits per plan year	**Inpatient:** 40% of In-Network Rate after Deductible **Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
Retail *Up to 30-day supply*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Mail-order *90-day supply*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum copayment **Tier B:** 30%. No maximum copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate. No maximum copayment **Tier B:** 30% of In-Network Rate. No maximum copayment	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo | *Up to 30-day supply*	**Tier A:** 20%. $150 maximum copayment **Tier B:** 30%. $225 maximum copayment **Tier C:** 20%. No maximum copayment	Not covered

	In-Network Provider	Out-of-Network Provider
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	No charge, up to $4,000	
Allergy Serum	10% of In-Network Rate	40% of In-Network Rate after Deductible
Chiropractic Care | *Up to 20 visits per plan year*	No charge after $40 Copayment per visit	40% of In-Network Rate after Deductible
Durable Medical Equipment, DME *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	20% of In-Network Rate	40% of In-Network Rate after Deductible
Medical Supplies	20% of In-Network Rate	40% of In-Network Rate after Deductible
Hearing Aids *Requires Preauthorization*	20% of In-Network Rate, up to one pair of hearing aids every three years	Not covered
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	10% of In-Network Rate	40% of In-Network Rate after Deductible
Infertility Services* | *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum*	50% of In-Network Rate	50% of In-Network Rate after Deductible
Injections | *Requires Preauthorization if over $750*	**Under $50:** No charge **Over $50:** 20% of In-Network Rate	40% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *Non-surgical*	Not covered	Not covered
Dental Accident Benefit	10% of In-Network Rate. See Limitations	10% of In-Network Rate. See Limitations
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services	No charge	Not covered
Routine Vision Exams *1 visit per year*	No charge after applicable office Copayment per visit	Not covered
Routine Hearing Exams *1 visit per year*	No charge after applicable office Copayment per visit	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	No charge, one occurrence per plan year	No charge, one occurrence per plan year

Silver Plan » MEDICAL BENEFITS GRID

SUMMIT
ADVANTAGE
PREFERRED

Refer to the applicable Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

YOU PAY

	In-Network Provider	Out-of-Network Provider
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	$200 per individual, $600 per family	$500 per individual, $1,000 per family
Plan year Out-of-Pocket Maximum*	$4,500 per individual, $9,200 per family	$8,500 per individual, $17,000 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	20% of In-Network Rate after Deductible and $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	20% of In-Network Rate after Deductible and $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Rehabilitation | *Requires preauthorization*	20% of In-Network Rate after Deductible and $500 Copayment	40% of In-Network Rate after Deductible and $500 Copayment
Mental Health and Substance Abuse *Requires preauthorization*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after Deductible and $250 Copayment	40% of In-Network Rate after Deductible and $250 Copayment
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% of In-Network Rate after Deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	20% of In-Network Rate after Deductible and $150 Copayment	20% of In-Network Rate after Deductible and $150 Copayment, plus any balance billing above In-Network Rate
Urgent Care Facility	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Diagnostic Tests, X-rays	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *20 visits per plan year.*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible

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

	In-Network Provider	Out-of-Network Provider
PROFESSIONAL SERVICES		
Inpatient Physician Visits	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Surgery and Anesthesia	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Primary Care Office Visits *Includes office surgeries*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Specialist Office Visits *Includes office surgeries*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Emergency Room Specialist Visits	20% of In-Network Rate	20% of In-Network Rate, plus any balance billing above In-Network Rate
University of Utah Medical Group Office Visits *Preferred plan only. Includes office surgeries*	20% of In-Network Rate after Deductible	Not applicable
Diagnostic Tests, X-rays	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Mental Health/Substance Abuse *No Preauthorization for outpatient services.* *Inpatient services require Preauthorization*	**Inpatient:** 20% of In-Network Rate after Deductible **Outpatient:** 20% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 40% of In-Network Rate after Deductible **Outpatient:** 40% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
Retail *Up to 30-day supply*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Mail-order *90-day supply*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum copayment **Tier B:** 30%. No maximum copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after Deductible.No maximum copayment **Tier B:** 30% of In-Network Rate after Deductible. No maximum copayment	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo | *Up to 30-day supply*	**Tier A:** 20%. $150 maximum copayment **Tier B:** 30%. $225 maximum copayment **Tier C:** 20%. No maximum copayment	Not covered

	In-Network Provider	Out-of-Network Provider
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	No charge after Deductible, up to $4,000 (applies to In-network Provider Deductible)	
Allergy Serum	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Chiropractic Care | *Up to 20 visits per plan year*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Durable Medical Equipment, DME *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Medical Supplies	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Hearing Aids *Requires Preauthorization*	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Infertility Services* | *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Injections | *Requires Preauthorization if over $750*	20% of In-Network Rate after Deductible	40% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *Non-surgical*	Not covered	Not covered
Dental Accident Benefit	10% of In-Network Rate. See Limitations	10% of In-Network Rate. See Limitations
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services	No charge	Not covered
Routine Vision Exams *1 visit per year*	No charge	No charge
Routine Hearing Exams *1 visit per year*	Not covered	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	No charge, one occurrence per plan year	No charge, one occurrence per plan year

Bronze Plan » MEDICAL BENEFITS GRID

SUMMIT ADVANTAGE PREFERRED

Refer to the applicable Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

YOU PAY

	In-Network Provider	Out-of-Network Provider
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	$750 per individual, $2,250 per family	$2,250 per individual, $4,500 per family
Plan year Out-of-Pocket Maximum*	$6,350 per individual, $12,700 per family	$10,750 per individual, $21,500 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	25% of In-Network Rate after Deductible and $500 Copayment	45% of In-Network Rate after Deductible and $500 Copayment
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	25% of In-Network Rate after Deductible and $500 Copayment	45% of In-Network Rate after Deductible and $500 Copayment
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Rehabilitation | *Requires preauthorization*	25% of In-Network Rate after Deductible and $500 Copayment	45% of In-Network Rate after Deductible and $500 Copayment
Mental Health and Substance Abuse *Requires preauthorization*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	25% of In-Network Rate after Deductible and $250 Copayment	45% of In-Network Rate after Deductible and $250 Copayment
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	25% of In-Network Rate after Deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	25% of In-Network Rate after Deductible and $150 Copayment	25% of In-Network Rate after Deductible and $150 Copayment, plus any balance billing above In-Network Rate
Urgent Care Facility	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Diagnostic Tests, X-rays	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Chemotherapy, Radiation, and Dialysis	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *20 visits per plan year.*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible

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

	In-Network Provider	Out-of-Network Provider
PROFESSIONAL SERVICES		
Inpatient Physician Visits	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Surgery and Anesthesia	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Primary Care Office Visits *Includes office surgeries*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Specialist Office Visits *Includes office surgeries*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Emergency Room Specialist Visits	25% of In-Network Rate	25% of In-Network Rate, plus any balance billing above In-Network Rate
University of Utah Medical Group Office Visits *Preferred plan only. Includes office surgeries*	25% of In-Network Rate after Deductible	Not applicable
Diagnostic Tests, X-rays	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Mental Health/Substance Abuse *No Preauthorization for outpatient services. Inpatient services require Preauthorization*	**Inpatient:** 25% of In-Network Rate after Deductible **Outpatient:** 25% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 45% of In-Network Rate after Deductible **Outpatient:** 45% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS		
Retail *Up to 30-day supply*	**Tier 1:** $15 Copayment **Tier 2:** 25% of discounted cost. $30 minimum, $90 maximum Copayment **Tier 3:** 50% of discounted cost. $55 minimum, $200 maximum Copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Mail-order *90-day supply*	**Tier 1:** $25 Copayment **Tier 2:** 25% of discounted cost. $50 minimum, $150 maximum Copayment **Tier 3:** 50% of discounted cost. $100 minimum, $200 maximum Copayment	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum copayment **Tier B:** 30%. No maximum copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% of In-Network Rate after Deductible. No maximum copayment **Tier B:** 30% of In-Network Rate after Deductible. No maximum copayment	**Tier A:** 40% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo	*Up to 30-day supply*	**Tier A:** 20%. $150 maximum copayment **Tier B:** 30%. $225 maximum copayment **Tier C:** 20%. No maximum copayment	Not covered

	In-Network Provider	Out-of-Network Provider
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	No charge after Deductible, up to $4,000 (applies to In-network Provider Deductible)	
Allergy Serum	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Chiropractic Care | *Up to 20 visits per plan year*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Durable Medical Equipment, DME *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Medical Supplies	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Hearing Aids *Requires Preauthorization*	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Infertility Services* | *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Injections | *Requires Preauthorization if over $750*	25% of In-Network Rate after Deductible	45% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *Non-surgical*	Not covered	Not covered
Dental Accident Benefit	10% of In-Network Rate. See Limitations	10% of In-Network Rate. See Limitations
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services	No charge	Not covered
Routine Vision Exams *1 visit per year*	No charge	No charge
Routine Hearing Exams *1 visit per year*	Not covered	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	No charge, one occurrence per plan year	No charge, one occurrence per plan year

Copper HSA » MEDICAL BENEFITS GRID

SUMMIT
ADVANTAGE
PREFERRED

Refer to the applicable Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	$1,750 per single, $3,500 per family	$1,750 per single, $3,500 per family
Plan year Out-of-Pocket Maximum*	$3,500 per single, $7,000 per family	$3,500 per single, $7,000 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Rehabilitation | *Requires preauthorization*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Mental Health and Substance Abuse *Requires preauthorization*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	25% of In-Network Rate after Deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	25% of In-Network Rate after Deductible	25% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
Urgent Care Facility	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Diagnostic Tests, X-rays	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Chemotherapy, Radiation, and Dialysis	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *20 visits per plan year.*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible

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

	In-Network Provider	Out-of-Network Provider
PROFESSIONAL SERVICES		
Inpatient Physician Visits	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Surgery and Anesthesia	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Primary Care Office Visits *Includes office surgeries*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialist Office Visits *Includes office surgeries*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Emergency Room Specialist Visits	25% of In-Network Rate after deductible	25% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
University of Utah Medical Group Office Visits *Preferred plan only. Includes office surgeries*	25% of In-Network Rate after Deductible	Not applicable
Diagnostic Tests, X-rays	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Mental Health/Substance Abuse *No Preauthorization for outpatient services. Inpatient services require Preauthorization*	**Inpatient:** 20% of In-Network Rate after Deductible **Outpatient:** 20% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 50% of In-Network Rate after Deductible **Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS *All pharmacy benefits for The STAR Plan are subject to the deductible*		
Retail *Up to 30-day supply*	**Tier 1:** 25% of discounted cost **Tier 2:** 25% of discounted cost **Tier 3:** 35% of discounted cost	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Mail-order *90-day supply*	**Tier 1:** 25% of discounted cost **Tier 2:** 25% of discounted cost **Tier 3:** 35% of discounted cost	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 25%. No maximum copayment **Tier B:** 30%. No maximum copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 25% of In-Network Rate. No maximum copayment **Tier B:** 30% of In-Network Rate. No maximum copayment	**Tier A:** 45% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo	*Up to 30-day supply*	**Tier A:** 25%. $150 maximum copayment **Tier B:** 30%. $225 maximum copayment **Tier C:** 20%. No maximum copayment	Not covered

	In-Network Provider	Out-of-Network Provider
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	No charge after Deductible, up to $4,000	
Allergy Serum	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Chiropractic Care | *Up to 20 visits per plan year*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Durable Medical Equipment, DME *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Medical Supplies	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Hearing Aids *Requires Preauthorization*	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Infertility Services | *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Injections | *Requires Preauthorization if over $750*	25% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *Non-surgical*	Not covered	Not covered
Dental Accident Benefit	10% of In-Network Rate after Deductible. See Limitations	10% of In-Network Rate after Deductible. See Limitations
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services	No charge	Not covered
Routine Vision Exams *1 visit per year*	No charge	Not covered
Routine Hearing Exams *1 visit per year*	Not covered	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	No charge, one occurrence per plan year	No charge, one occurrence per plan year

Core HSA » MEDICAL BENEFITS GRID

SUMMIT ADVANTAGE PREFERRED

Refer to the applicable Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

	YOU PAY	
	In-Network Provider	**Out-of-Network Provider**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	$1,750 per single, $3,500 per family	$1,750 per single, $3,500 per family
Plan year Out-of-Pocket Maximum*	$6,000 per single, $12,000 per family	$6,000 per single, $12,000 per family
INPATIENT FACILITY SERVICES		
Medical and Surgical | *All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details*	50% of In-Network Rate (In-Network Rate) after Deductible	70% of In-Network Rate (In-Network Rate) after Deductible
Skilled Nursing Facility | *Non-custodial Up to 60 days per plan year. Requires preauthorization*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Hospice | *Up to 6 months in a 3-year period. Requires preauthorization*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Rehabilitation | *Requires preauthorization*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Mental Health and Substance Abuse *Requires preauthorization*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	50% of In-Network Rate after Deductible	70% of In-Network Rate after Deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	50% of In-Network Rate after Deductible	
Emergency Room *Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
Urgent Care Facility	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Diagnostic Tests, X-rays	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Chemotherapy, Radiation, and Dialysis	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible. Dialysis requires preauthorization
Physical and Occupational Therapy *20 visits per plan year.*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible

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

	In-Network Provider	Out-of-Network Provider
PROFESSIONAL SERVICES		
Inpatient Physician Visits	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Surgery and Anesthesia	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Primary Care Office Visits *Includes office surgeries*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialist Office Visits *Includes office surgeries*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Emergency Room Specialist Visits	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
University of Utah Medical Group Office Visits *Preferred plan only. Includes office surgeries*	50% of In-Network Rate after Deductible	Not applicable
Diagnostic Tests, X-rays	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Mental Health/Substance Abuse *No Preauthorization for outpatient services. Inpatient services require Preauthorization*	**Inpatient:** 50% of In-Network Rate after Deductible **Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year	**Inpatient:** 50% of In-Network Rate after Deductible **Outpatient:** 50% of In-Network Rate after Deductible, up to 20 visits per plan year
PRESCRIPTION DRUGS *All pharmacy benefits for The STAR Plan are subject to the deductible*		
Retail *Up to 30-day supply*	**Tier 1:** 50% of discounted cost **Tier 2:** 50% of discounted cost **Tier 3:** 60% of discounted cost	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Mail-order *90-day supply*	**Tier 1:** 50% of discounted cost **Tier 2:** 50% of discounted cost **Tier 3:** 60% of discounted cost	Not covered
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 50%. No maximum copayment **Tier B:** 50%. No maximum copayment	Plan pays up to discounted cost, minus the applicable Copayment. Member pays any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 50% of In-Network Rate. No maximum copayment **Tier B:** 50% of In-Network Rate. No maximum copayment	**Tier A:** 70% of In-Network Rate after deductible. No maximum co-pay **Tier B:** 70% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo	*Up to 30-day supply*	**Tier A:** 50%. $150 maximum copayment **Tier B:** 50%. $225 maximum copayment **Tier C:** 20%. No maximum copayment	Not covered

	In-Network Provider	Out-of-Network Provider
MISCELLANEOUS SERVICES		
Adoption | *See Limitations*	No charge after Deductible, up to $4,000	
Allergy Serum	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Chiropractic Care | *Up to 20 visits per plan year*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Durable Medical Equipment, DME *Except for Sleep Disorder Equipment, DME over $750, rentals that exceed 60 days, or as indicated in Appendix A of the Master Policy require Preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Medical Supplies	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Hearing Aids *Requires Preauthorization*	20% of In-Network Rate after Deductible, up to one pair of hearing aids every three years	Not covered
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Infertility Services | *Select services only. See Master Policy. Up to $1,500 per plan year. $5,000 Lifetime Maximum*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Injections | *Requires Preauthorization if over $750*	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction *Non-surgical*	Not covered	Not covered
Dental Accident Benefit	10% of In-Network Rate after Deductible. See Limitations	10% of In-Network Rate after Deductible. See Limitations
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services	No charge	Not covered
Routine Vision Exams *1 visit per year*	No charge	Not covered
Routine Hearing Exams *1 visit per year*	Not covered	Not covered
Diabetes Education *Must be for the diagnosis of diabetes*	No charge, one occurrence per plan year	No charge, one occurrence per plan year

Wellness and Value-Added Benefits

Healthy Utah

PEHP Healthy Utah is a free program aimed at enhancing the well-being of members by increasing awareness of health risks and the importance of making healthy lifestyle choices, and providing support in making health-related lifestyle changes. PEHP Healthy Utah offers a variety of programs, services, cash incentives, and resources to help members get and stay well.

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

FOR MORE INFORMATION

PEHP Healthy Utah
801-366-7300 or 855-366-7300
» **Email: healthyutah@pehp.org**
» **Web: www.healthyutah.org**

PEHP Healthy Utah rebates may be taxable. Please consult with your tax advisor for tax advice concerning your benefits.

WeeCare

PEHP WeeCare is our pregnancy case management service. It's a prenatal risk reduction program that offers education and consultation to expectant mothers.

Participate in PEHP WeeCare and you may qualify to get free pre-natal vitamins, free books, and cash incentives.

While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

FOR MORE INFORMATION

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

PEHP Waist Aweigh

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

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

FOR MORE INFORMATION

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

If you are unable to meet the medical standards to qualify for the program because it is medically unadvisable or unreasonably difficult due to a medical condition, upon written notification, PEHP shall provide you with a reasonable alternative standard to qualify for the program. Members who claim the PEHP Waist Aweigh cash incentive for reaching and maintaining a BMI of 24.9 or less are ineligible for the Healthy Utah rebate for BMI reduction. The total amount of rewards cannot be more than 20% of the cost of employee-only coverage under the plan. PEHP Waist Aweigh rebates may be taxable. Please consult with your tax advisor for tax advice concerning your benefits.