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» Claims or Other Questions? Contact a Health Benefits Advisor in your [Secure Message Center](#) or at 801-366-7555.

# Benefit Changes & Reminders

## STAR HSA Plan Changes

Starting July 1, 2024, the deductible is changing on the STAR HSA Plan to comply with minimum deductible limits under federal law for qualified high-deductible health plans. There will also be changes to the out-of-pocket maximum (OOPM) to bring them in line with the Traditional Plan. For double/family plans, there will be an individual OOPM cap of \$4,000, providing relief for members facing high healthcare costs. This means that if one family member incurs significant expenses, their out-of-pocket spending will be capped at \$4,000, rather than having to meet the entire family OOPM as in the previous plan year. If you're on the single plan, your employer HSA contribution will increase to make up for your higher plan limits. [More details](#)

## Free Fast-Acting Insulin & \$10 Test Strips

You can get fast-acting insulin at No Cost. Just ask your doctor to switch your prescription to Insulin Lispro (generic Humalog). Plus, you can get FreeStyle test strips with a \$10 copay and have access to a Continuous Glucose Monitor (CGM) to help you control your diabetes. These benefits are available to all members, including those on the STAR HSA plan **before deductible**. [See all your diabetes management benefits](#)

## PEHP Cost Tools and Cash Back

Next time you need medical care, find lower-cost medical services and cash back opportunities up to \$2,000 using [PEHP Cost Tools](#).

## Mental Health Care & Services

If you or a loved one have a mental health crisis, you can get immediate help by calling the national crisis line at 988. You and your family have access to counseling services at no cost and for any reason through Blomquist Hale. Services are confidential, and they also offer a 24/7 crisis hotline. Call them at 1-800-926-9619. See other helpful [mental health care resources](#).

## Free Preventive Care Benefits

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider — even before you meet your deductible. Free services include colonoscopy, mammograms, annual physical exam, and vaccinations. [See complete list of services and eligibility](#).

» *PEHP specialist Taylor Hooton*



# Benefit Changes & Reminders

## Free Wellness Classes and Programs to Improve Your Health

Discover your path to wellness with PEHP and win exciting prizes along the way! Whether you're trying to be more active, improve your eating habits, boost your mental well-being, or get parenting support - you'll find something to help you achieve your health and wellness goals.

[Start your wellness journey.](#)

## Guaranteed Lowest Drug Price

When you fill a covered prescription, rest assured that you'll always get the best price when you visit the pharmacy. If savings are available via GoodRx, your prescription will automatically process with the lower cost, and we'll apply the lower paid amount to your deductible and out-of-pocket maximum. No need to show the pharmacist a GoodRx coupon.

**PEHP Medical Per Pay Period Rates**

	Single		Employee +1		Employee +2	
	2023-24	2024-25	2023-24	2024-25	2023-24	2024-25
<b>Traditional</b>						
Advantage (IHC)	\$36.67	\$39.23	\$75.60	\$80.88	\$100.93	\$107.97
Summit	\$36.67	\$39.23	\$75.60	\$80.88	\$100.93	\$107.97
<b>Star/HSA</b>						
Advantage	\$0	\$0	\$0	\$0	\$0	\$0
Summit	\$0	\$0	\$0	\$0	\$0	\$0
HSA Contribution	\$33.09	\$33.09	\$66.18	\$66.18	\$66.18	\$66.18



# Things to Consider before choosing medical plan

## 1

### How often do you use your medical plan?

- If you only have routine or office visits, switching to a lower-cost plan and paying the full cost of office visits may be more cost-effective. What's more important: lower upfront costs (Traditional Plan) or more take home pay (STAR HSA plan)?
- Chronic conditions, prescriptions, specialists, etc. How much did you spend on these things last year? The year before?
- Anything on the horizon - having a child, upcoming surgery or service?

### Did you know?

You can download your claims history from your PEHP account to see how much you spend on healthcare annually.

## 2

### How much will covered healthcare cost you?

**Annual premium** - see [page 4](#) for plan amounts

- Remember, this is deducted from your paycheck whether you go to the doctor or not.

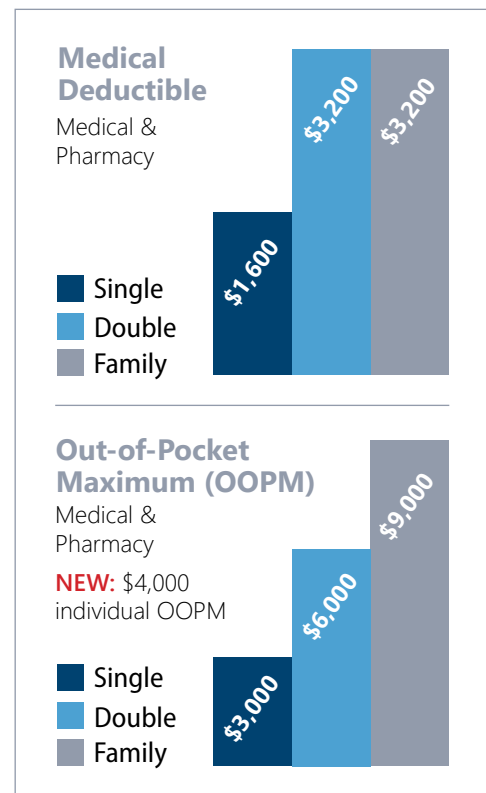
#### Deductible & Out-of-Pocket Maximum (OOPM)

- Traditional Plan: copays go towards your OOPM, but not your deductible. Your total out of pocket costs would be the deductible + OOPM. Remember, each person has their own individual deductible & OOPM until the double/family limits are met.
- STAR HSA: The OOPM is the most you will pay in a year for covered in-network services. Your OOPM includes what you've paid in your deductible.

 **STAR HSA**  
**Medical Plans**

**STAR HSA Plan Highlights**

- » You get money in an HSA for health-related expenses to offset a higher deductible. HSA funds carry over from year-to-year and grow tax-free. You never forfeit what you don't spend.
- » It covers more [preventive services](#) paid at 100% compared to other plans. See a list of medications on page 19 of the [Covered Drug List](#).
- » Your family has a set deductible, but each family member has their own out-of-pocket maximum capped at \$4,000. Once the individual meets the \$4,000 amount, the individual is covered 100% for covered, in-network services. [More details](#)
- » Your out-of-pocket maximum includes what you've paid toward your deductible.

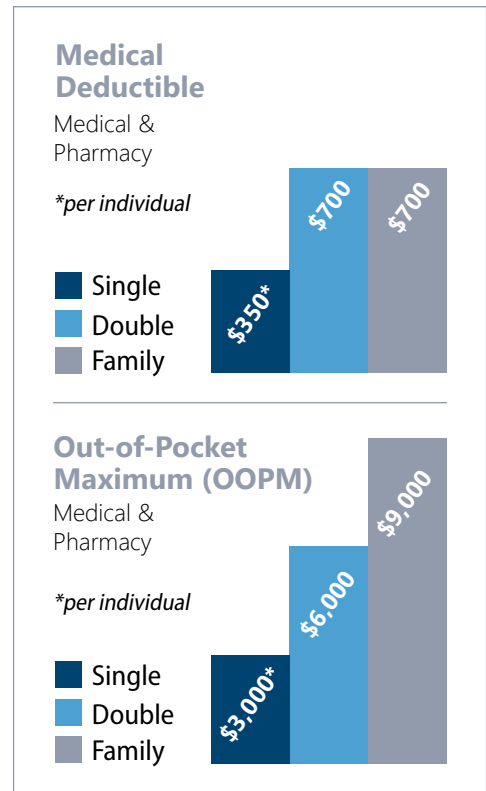


[See Medical Plan Costs](#)

 **Traditional Medical Plans** (continued)

**Traditional Plan Highlights**

- » Lower deductible with fixed co-pays for predictable costs.
- » Each family member has their own deductible and out-of-pocket maximum. There is also a deductible and out-of-pocket maximum that applies to the family as a whole.
- » Option to enroll in a Flexible Spending Account (FLEX\$) for qualified health expenses, which is funded through pre-tax payroll deductions.
- » Copays and pharmacy costs go towards the OOPM, but not toward the deductible.



[See Medical Plan Costs](#)



**STAR HSA**

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$1,600 Double/family plans: \$3,200 <i>One person or a combination can meet the \$3,200 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b>	Single plans: \$3,000 Double plans: \$4,000 per person, \$6,000 per double Family plans: \$4,000 per person, \$9,000 per family <i>One person can only meet \$4,000, or a combination can meet the double/family maximum</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	20% after deductible	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Specialist Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	20% after deductible	20% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

\*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.



# Weber State University 2024-25 » Medical Benefits Grid » STAR HSA

	In-Network Provider	Out-of-Network Provider* <small>Balance billing may apply</small>
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	<b>Tier A:</b> 40%. No maximum co-pay <b>Tier B:</b> 50%. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C1:</b> 10%. No maximum co-pay <b>Tier C2:</b> 20%. No maximum co-pay <b>Tier C3:</b> 30%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	20% after deductible	40% after deductible
<b>Emergency Room</b> <i>Emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% after deductible	20% after deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	20% after deductible	40% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Hospital Services</b> <i>Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>ART requires Preauthorization. Excludes multiple-embryo ART implants</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	20% after deductible	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires Preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Home Hospice</b>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	20% after deductible	40% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$1,000 lifetime maximum. See Master Policy for details</i>	20% after deductible	40% after deductible



**Traditional** (Non-HSA)  
Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

**In-Network Provider**

**Out-of-Network Provider\***

*Balance billing may apply*

<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Does not apply to Out-of-Pocket Maximum</i>	Single plans: \$350 Double/family plans: \$350 per person, \$700 per family <i>One person cannot meet more than \$350</i>	
<b>Plan year Out-of-Pocket Maximum</b> <i>Please refer to the Master Policy for exceptions to the out-of-pocket maximum.</i>	Single plans: \$3,000 Double plans: \$3,000 per person, \$6,000 per double Family plans: \$3,000 per person, \$9,000 per family <i>One person cannot meet more than \$3,000</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	Starting at \$10 co-pay per visit	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	\$25 co-pay per visit <b>IHC:</b> \$35 co-pay per visit for Summit network <b>University of Utah Medical Group:</b> \$35 co-pay per visit	40% after deductible
<b>Specialist Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	\$35 co-pay per visit <b>IHC:</b> \$45 co-pay per visit for Summit network <b>University of Utah Medical Group:</b> \$45 co-pay per visit	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	\$35 co-pay per visit	\$35 co-pay per visit
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></b>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

\*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

# Weber State University 2024-25 » Medical Benefits Grid » Traditional

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>SPECIALTY DRUGS   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></b>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% after deductible. No maximum co-pay <b>Tier B:</b> 30% after deductible. No maximum co-pay	<b>Tier A:</b> 40% after deductible. No maximum co-pay <b>Tier B:</b> 50% after deductible. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C1:</b> 10%. No maximum co-pay <b>Tier C2:</b> 20%. No maximum co-pay <b>Tier C3:</b> 30%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	\$45 co-pay per visit	40% after deductible
<b>Emergency Room</b> <i>Emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% of In-Network Rate, minimum \$150 co-pay per visit	20% of In-Network Rate, minimum \$150 co-pay per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	Applicable co-pay per visit	40% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Hospital Services</b> <i>Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>ART requires Preauthorization. Excludes multiple-embryo ART implants</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	Applicable office co-pay per visit	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires Preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Home Hospice</b>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	20% after deductible	40% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$1,000 lifetime maximum. See Master Policy for details</i>	20% after deductible	40% after deductible

# Medical Networks

## PEHP Advantage

**37 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS**

Network consists of predominantly Intermountain Health providers and facilities.

### 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  
Intermountain Layton Hospital

### Duchesne County

Uintah Basin Medical Center

### Garfield County

Garfield Memorial Hospital

### Grand County

Moab Regional Hospital

### Iron County

Cedar City Hospital

### Juab County

Central Valley Medical Center

### Kane County

Kane County Hospital

### Millard County

Delta Community Hospital  
Fillmore Community Hospital

### Salt Lake County

Alta View Hospital  
Intermountain Medical Center  
The Orthopedic Specialty Hospital (TOSH)  
LDS Hospital

### Salt Lake County (cont)

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 Hospital

### 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  
Primary Children's Hospital – Lehi  
Spanish Fork Hospital  
Utah Valley Hospital

### Wasatch County

Heber Valley Medical Center

### Washington County

St. George Regional Hospital

### Weber County

McKay-Dee Hospital

## PEHP Summit

**41 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS**

Network consists of predominantly CommonSpirit (Holy Cross), MountainStar, and University of Utah hospitals & clinics providers and facilities.

### Beaver County

Beaver Valley Hospital  
Milford Valley Memorial Hospital

### Box Elder County

Bear River Valley Hospital  
Brigham City Community Hospital

### Cache County

Cache Valley Hospital

### Carbon County

Castleview Hospital

### Davis County

Davis Hospital  
Lakeview Hospital

### Duchesne County

Uintah Basin Medical Center

### Garfield County

Garfield Memorial Hospital

### Grand County

Moab Regional Hospital

### Iron County

Cedar City Hospital

### Juab County

Central Valley Medical Center

### Kane County

Kane County Hospital

### Millard County

Delta Community Hospital  
Fillmore Community Hospital

### Salt Lake County

Huntsman Cancer Hospital  
Jordan Valley Hospital  
Jordan Valley Hospital – West-  
Huntsman Cancer Hospital

### Salt Lake County (cont)

Lone Peak Hospital  
Primary Children's Medical Center  
Riverton Children's Unit  
St. Marks Hospital  
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 Hospital

### Summit County

Park City Medical Center

### Tooele County

Mountain West Medical Center

### Uintah County

Ashley Valley Medical Center

### Utah County

Holy Cross Hospital – Mountain Point  
Mountain View Hospital  
Primary Children's Hospital – Lehi  
Timpanogos Regional Hospital

### Wasatch County

Heber Valley Medical Center

### Washington County

St. George Regional Hospital

### Weber County

Ogden Regional Medical Center

## Non-Covered Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit.

[See a list of Non-Covered Providers.](#)

## DID YOU KNOW?

In-network rates for services and facilities may be different between the two. Compare provider costs at [www.pehp.org/providerlookup](http://www.pehp.org/providerlookup)

## PEHP Wellness Programs

As a PEHP member, you have access to wellness programs and activities to help you stay on top of your health. Below are some of the programs you can participate in:

- » **Biometric Screenings** - Subscribers and their spouses are eligible to attend one Healthy Utah biometric screening each plan year free of charge.
- » **Earn Cash Rebates\*** – Get cash rewards for participating in wellness programs and activities.
- » **Diabetes Management** – Receive education and support from a registered dietitian to manage or prevent diabetes.
- » **Pregnancy Resources** – Enroll in PEHP WeeCare to get pregnancy and postpartum support to help you have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy.
- » **Healthy Eating** – Practice expert strategies to plan healthy meals, streamline grocery shopping, and try new ingredients to avoid menu monotony.
- » **Weight Management** – Meet your health and weight management goals with personalized help from a health coach and registered dietitian.



- » **Physical Activity** – Stay active and physically fit with weekly motivational tips and resources from a certified personal trainer.



- » **Mental & Emotional Well-Being** – Stay on top of your mental and emotional health with several tips, exercises, and resources.
- » **Financial Wellness** – Get on track with personal finances to create financial peace of mind.
- » **Family & Social Well-Being** – Check out a library of parenting materials or virtually attend monthly parenting classes.
- » **Webinars** – Learn about current health and wellness topics.

### FOR MORE INFORMATION

PEHP Wellness Programs

801-366-7300 | 855-366-7300

» E-mail: [healthyutah@pehp.org](mailto:healthyutah@pehp.org)

» Web: [www.pehp.org/wellness](http://www.pehp.org/wellness)

## Value Added Benefits

### Free Fast-Acting Insulin

You can get fast-acting insulin at no cost. Just ask your doctor to switch your prescription to Insulin Lispro (generic Humalog). Plus, you can get FreeStyle test strips with a \$10 copay and have access to a Continuous Glucose Monitor (CGM) to help you control your diabetes. These benefits are available to all members, including those on the STAR HSA plan before deductible.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/diabetes](http://www.pehp.org/diabetes)

### Legal Guardianship

This benefit allows children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. To continue coverage, the guardian child must have been enrolled in coverage prior to being 18 years of age and met the federal qualifications for coverage as a guardian child. Call PEHP to learn more, 801-366-7555 or 800-765-7347.

### PEHPplus

PEHPplus provides savings of up to 50 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/pehpplus](http://www.pehp.org/pehpplus)

### PEHP Value Providers

PEHP Value Providers include outstanding healthcare providers available to PEHP members with the lowest out-of-pocket costs. The next time you need care, don't forget these options for value and convenience.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/valueproviders](http://www.pehp.org/valueproviders)

### Preventive Care

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider – even before you meet your deductible. If you're on the STAR HSA Plan, additional preventive visits and certain chronic medications are covered before you meet your deductible. See a list of medications on page 19 of the [Covered Drug List](#).

#### FOR MORE INFORMATION

» Web: [www.pehp.org/preventiveservices](http://www.pehp.org/preventiveservices)

### Childbirth Doula Services

Birth doula services are a covered health plan benefit for eligible PEHP members through June 30, 2026.

Only pregnant employees, or their dependents, who are covered by PEHP are eligible for in-network doula services.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/weecare](http://www.pehp.org/weecare)



Brightside Health



## Get back to being you

Stress, panic, and frustration are real ways that anxiety and depression can show up in our lives. Take the first step toward feeling like you again with Brightside Health.



Brightside Health and PEHP have partnered to provide you with virtual in-network mental health care—from anywhere.

Our expert specialists pair empathy with expertise to deliver therapy and psychiatry. Meet with your psychiatric provider or therapist virtually in as little as 48 hours.

Start by taking our free assessment at [brightside.com/pehp](https://brightside.com/pehp)

### We're here to support you every step of the way

- ✓ Video consults with your psychiatric provider as needed
- ✓ Weekly video sessions with your therapist
- ✓ Skill-building therapy lessons and practice
- ✓ Convenient progress tracking
- ✓ Unlimited messaging with your specialists

### Getting started with Brightside Health is easy

#### 1. Take our free assessment.

Answer a short set of questions about how you're doing to help us understand your symptoms.

#### 2. Meet 1:1 with your licensed specialist.

Whether you choose therapy, psychiatry, or both, your specialist will work with you on a comprehensive treatment plan.

#### 3. Get online support at your fingertips.

Stay on track with video visits, messaging, and check-ins. Get medication delivered to your door, if prescribed.

Brightside Health members feel better faster, and stay that way longer.

### Real stories. Real results.



I feel MUCH IMPROVED! The care I have received has been excellent! My medication works well for me, and the personal care I have received has been wonderful! My provider listens to me with understanding and compassion!

TONYA T

★★★★★



I am just blown away by how EASY this has all been. Brightside Health makes mental health care effective and accessible.

GINA L

★★★★★



I am finally starting to feel like myself again.

JENNIFER S

★★★★★



Get back to feeling like you. Visit [brightside.com/pehp](https://brightside.com/pehp)

## PEHP Mental Health Care & Services



Visit [www.pehp.org/mentalhealth](http://www.pehp.org/mentalhealth) to find these resources and more:

### Self-Care



Self-Paced Videos to Enhance Your Mental Well-Being:

- » Burnout, fatigue and what to do about it.
- » Managing anxiety & worry.
- » Understanding & managing depression.
- » Qualities & traits of resilient people.
- » Suicide prevention: Starting a conversation.

### Parenting Resources



[ParentGuidance.org](http://ParentGuidance.org) provides free parenting resources to members.

Some of the concepts the program explores:

- » Meeting basic needs.
- » Creating secure attachments.
- » Attuning to your child.
- » Identity formation.

### Counseling



- » Ask your employer about any Employee Assistance Programs (EAP) available to you. Many plans pay for a limited number of mental health visits without requiring a diagnosis.
- » Find in-network counselors in the PEHP Provider Directory under the Mental Health category.

### Crisis/Emergency



- » **National Suicide & Crisis Lifeline:** Dial 988 for immediate support 24/7.
- » **Emergency Room:** If you require emergency care, visit the nearest Emergency Room.

### Psychiatry



- » Find in-network psychiatrists in the PEHP Provider Directory.
- » Meet with an in-network psychiatrist within 48 hours after an assessment at [brightside.com/pehp](http://brightside.com/pehp).

## Life Assistance Counseling

### Blomquist Hale

SOLUTIONS

## WHEN LIFE GETS CHALLENGING WE CAN HELP

The Blomquist Hale Life Assistance Counseling program provides direct, **face-to-face** guidance to address virtually any stressful life situation or problem. Not to mention there is absolutely **no cost** to you. Meeting with our team is simple. Call to schedule an appointment today. **(800) 926-9619**


### Count On:


- 24/7 Crisis Service
- 100% Confidential
- Professional, Friendly Team
- Convenient Locations
- Extended Hours
- No Co-pay Required

### WE CAN HELP WITH

Marital & Family Counseling 

Stress, Anxiety or Depression 

Personal & Emotional Challenges 

Grief or Loss 

Financial or Legal Problems 

Substance Abuse or Addictions 

Senior Care Planning 

## PEHP Cost Tools

### Find Quality Care & Best Value

Finding quality care at the right place is important. PEHP has several cost comparison tools that help you shop for the best providers and the best value.

To get started, log in to your PEHP account and click “Find Providers & Costs” in the top menu.

### Find and Compare Providers



Under the “Find a Provider” tab, you can search for doctors and other healthcare providers in your network, see and compare cost information, and read reviews from other PEHP members. Plus, you can see how often a doctor refers lab work to a costly hospital or lower-cost independent lab.

### Find and Compare Healthcare Facilities



Under the “Find a Facility” tab, you can search for healthcare facilities (e.g. hospitals, clinics, surgical centers) in your network, and see and compare cost information.

### Looking for Lower Drug Costs?



Click on “Compare Prescription Costs.” You’ll see medication prices from different pharmacies, including home delivery, which is often less expensive.

To get the best deal, use medications on lower tiers in the PEHP Covered Drug List – a list of prescription medications available to members at lower costs.

These cost comparison tools are just one way we strive to make healthcare costs transparent, so you decide where to go for the best care and value.



## Health Accounts

### Health Savings Account (HSA)

An HSA is like a flex account, but better.

- » HSA funds roll over yearly and never expire, even when you change employers.
- » Contributions are tax-and-FICA-free, grow tax-free, and can be used for eligible expenses tax-free.
- » Your employer contributes funds to help fund future health needs and retirement. Check with your employer on how much and how often they contribute.
- » Penalty-free withdrawals are available post age 65.

To qualify, you must be enrolled in a high deductible plan like STAR HSA.

#### 2024 HSA contribution limits:

**Single: \$4,150** (Total from employer + employee)

**Double/Family: \$8,300** (Total from employer + employee)

PEHP enrolls you in the HSA, but HealthEquity administers your account. HealthEquity will issue you a VISA card to pay for eligible expenses or you can submit your receipt and reimburse yourself from your HSA account.

### Flexible Spending Account (FLEX\$)

FLEX\$ is a flexible spending account that saves you money by setting aside a portion of your pre-tax salary to pay eligible expenses. There are two different FLEX\$ accounts – one for medical expenses and another to help with dependent childcare costs.

- » Great option to save for expenses if you're not eligible for an HSA.
- » If you sign up for a FLEX\$ account, PEHP will frontload your elected funds at the beginning of the plan year and issue you a Mastercard to use as payment for eligible expenses. Eligible expenses are set by the IRS.
- » If you do have an HSA, you can have a limited FLEX\$ account to pay for dental, vision, and post-deductible medical expenses only.
- » FLEX\$ accounts are use-or-lose. You can use your FSA funds through September 15, 2025 and submit claims for reimbursement through September 30. Any remaining funds after that will be forfeited to the new plan year, but anything beyond that is forfeited.
- » You must enroll in FLEX\$ each year during open enrollment to participate.

You can contribute up to \$3,200 in calendar year 2024.

[Learn More](#)

### Did you know?

FSA and HSA funds can be used to pay for more than just services covered by your medical, dental, or vision plan. You can also use funds for braces, LASIK, glasses/contacts, certain over-the-counter medications, and more. Search for qualifying expenses at <https://healthequity.com/qme>.

[See HSA Contributions](#)



**PROUDLY SERVING UTAH PUBLIC EMPLOYEES**

560 East 200 South » Salt Lake City, UT » 84102-2004 » 801-366-7555 or 800-765-7347 » [www.pehp.org](http://www.pehp.org)

## Important Notices About Your Benefits

Several important notices about your PEHP benefits are included with this letter. To learn more, see your benefits summary and master policy. Find them at your Benefits Information Library at PEHP for Members at [www.pehp.org](http://www.pehp.org). If you haven't created an online personal account, you'll need your PEHP ID and Social Security number. Find your PEHP ID number on your benefits card or your claims. Or call PEHP at 801-366-7555.

## Notice of COBRA Rights

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

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

### Qualified Beneficiary

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

### Who is Covered

#### » Employees

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

#### » Spouse of Employees

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

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

#### » Dependent Children

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

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

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

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

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

### Secondary Qualifying Event

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

### Separate Election

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

### Your Duties Under The Law

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

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

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

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

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

## **Election of COBRA Coverage**

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

## **Premium Payments**

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

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

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

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

## **Special Rules For Disability**

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

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

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

## **Special Rules For Retirees**

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

## **COBRA Coverage May Be Terminated**

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

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



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

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

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

### Questions

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

### Coverage Alternatives

There may be other Coverage options for you and your family. You are now able to buy Coverage through the Health Insurance Marketplace, which may cost less than COBRA. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Through the Marketplace you will also learn if you qualify for free or low-cost Coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You have 60 days from the time you lose your job-based Coverage to enroll in the Marketplace. After 60 days your special enrollment period will end and you may not be able to enroll, you should take action right away. In addition, during an "open enrollment" period, anyone can enroll in Marketplace Coverage.

If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through a "special enrollment period." If you terminate your COBRA early without a qualifying event, you will have to wait to enroll in Marketplace Coverage until the next open enrollment period, and could end up without any health Coverage in the interim.

If your COBRA ends you will be eligible to enroll in Marketplace Coverage through a special enrollment period event, if the Marketplace open enrollment has ended. If you

sign up for Marketplace Coverage instead of COBRA, you cannot switch to COBRA under any circumstances.

You can access information regarding the Marketplace at [HealthCare.gov](http://HealthCare.gov) or call 800-318-2596.

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

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

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

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

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

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

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

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

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

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

## Notice of Exemption from HIPAA

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

- » Application of the requirements of the 2008 Wellstone Act and the 1996 Mental Health Parity Act;
- » The exemption from this Federal requirement will be in effect for the 2018-19 plan year. The election may be renewed for subsequent plan years.

HIPAA also requires PEHP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under PEHP. There is no exemption from this requirement. The certificate provides evidence that you were covered under PEHP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a Pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

# Notice of Privacy Practices for Protected Health Information

effective January 7, 2020

Public Employees Health Program (PEHP) our business associates and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we have adopted the following privacy principles and information practices. PEHP is required by law to maintain the privacy of your protected health information, and to provide you with this notice which describes PEHP's legal duties and privacy practices. Our practices apply to current and former members.

It is the policy of PEHP to treat all member information with the utmost discretion and confidentiality, and to prohibit improper release in accordance with the confidentiality requirements of state and federal laws and regulations.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## Types of Personal Information PEHP collects

PEHP collects a variety of personal information to administer a member's health, coverage. Some of the information members provide on enrollment forms, surveys, and correspondence includes: address, Social Security number, and dependent information. PEHP also receives personal information (such as eligibility and claims information) through transactions with our affiliates, members, employers, other insurers, and health care providers. This information is retained after a member's coverage ends. PEHP limits the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

Disclosure of your protected health information within PEHP is on a need-to-know basis. All employees are required to sign a confidentiality agreement as a condition of employment, whereby they agree not to request, use, or disclose the protected health information of PEHP members unless necessary to perform their job.

## Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy,
- Better understand who, what, when, where, and why others may access your health information,
- Make more informed decisions when authorizing disclosure to others.

## Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that

compiled it, the information belongs to you. You have the rights as outlined in Title 45 of the Code of Federal Regulations, Parts 160 & 164:

- Request a restriction on certain uses and disclosures of your information, though PEHP is not required to agree with your requested restriction.
- Obtain a paper copy of the notice of information practices upon request (although we have posted a copy on our web site, you have a right to a hard copy upon request.)
- Inspect and obtain a copy of your health record.
- Amend your health records.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.

PEHP must provide the accounting within 60 days of receipt of your written request.

The accounting must include:

- Date of each disclosure
- Name and address of the organization or person who received the protected health information
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

## **Examples of Uses and Disclosures of Protected Health Information**

### ***PEHP will use your health information for treatment.***

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

Though PEHP does not provide direct treatment to individuals, we do use the health information described above for utilization and medical review purposes. These review procedures facilitate the payment and/or denial of payment of health care services you may have received. All payments or denial decisions are made in accordance with the individual plan provisions and limitations as described in the applicable PEHP Master Policies.

### ***PEHP will use your health information for payment.***

For example: A bill for health care services you received may be sent to you or PEHP. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

### ***PEHP will use your health information for health operations.***

For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. *Example: Your employer contracts with PEHP to provide a health plan, and PEHP provides your employer with certain statistics to explain the rates we charge.* For specific health information PEHP will only provide information after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

***There are certain uses and disclosures of your health information which are required or permitted by Federal Regulations and do not require your consent or authorization.***

***Examples include:***

***Public Health.***

As required by law, PEHP may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***Business Associates.***

There are some services provided in our organization through contacts with business associates. When such services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

***Food and Drug Administration (FDA).***

PEHP may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

***Workers Compensation.***

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

***Correctional Institution.***

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

***Law Enforcement.***

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

## **Our Responsibilities Under the Federal Privacy Standard**

PEHP is required to:

- Maintain the privacy of your health information, as required by law, and to provide individuals

with notice of our legal duties and privacy practices with respect to protected health information

- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality
- Implement a policy to discipline those who violate PEHP's privacy, confidentiality policies.
- Mitigate (lessen the harm of) any breach of privacy, confidentiality.
- To notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should we change our Notice of Privacy Practices you will be notified.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law. PEHP is prohibited from using or disclosing the genetic information of an individual for underwriting purposes.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. Other uses and disclosures not described in this notice of privacy practices require your written authorization.

## **Inspecting Your Health Information**

If you wish to inspect or obtain copies of your protected health information, please send your written request to PEHP, Customer Service, 560 East 200 South, Salt Lake City, UT 84102-2099. We will arrange a convenient time for you to visit our office for inspection. We will provide copies to you for a nominal fee. If your request for inspection or copying of your protected health information is denied, we will provide you with the specific reasons and an opportunity to appeal our decision.

## **For More Information or to Report a Problem**

If you have questions or would like additional information, you may contact the PEHP Customer Service Department at (801) 366-7555 or (800) 955-7347

If you believe your privacy rights have been violated, you can file a written complaint with our Chief Privacy Officer at:

ATTN: PEHP Chief Privacy Officer  
560 East 200 South  
Salt Lake City, UT 84102-2099.

Alternately, you may file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.