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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

New PEHP ID Card/Number Effective July 1

On July 1, PEHP will be moving you to a new claims payment system and online account to make managing your benefits easier. As part of this change, everyone will receive a new PEHP ID card with a number that begins with "M0000" to use beginning on July 1. You'll also need to create a new online account in July to see your benefits, claims, and find doctors. [Learn more](#)

New Cash Back & Copay Maps – The smartest path to care!

Finding high-quality, affordable healthcare just got easier. Beginning July 1, you'll have access to a new interactive map to locate low-cost-hospital alternatives for procedures like colonoscopies, imaging, surgeries, MRIs, and more. Copays no more than \$45 (Traditional Plan) and cash back up to \$3,900 on eligible services. [Learn more](#)

STAR HSA Plan Changes

To comply with federal regulations for qualified high-deductible health plans, the deductible will increase for the STAR HSA Plan. See new plan limits, premiums, and HSA employer contributions on [page 7](#).

Assisted Reproductive Technology (ART) Coverage Just Got Better

Starting July 1, Assisted Reproductive Technology (ART) services, including In Vitro Fertilization (IVF), will now be covered as part of your regular medical plan benefits. [See other pregnancy benefits & resources](#)

Take Control of Your Diabetes with Free Supplies

Members with diabetes can get the FreeStyle Libre 3 Plus CGM and fast-acting Insulin Lispro (generic Humalog) at No Cost. Plus, FreeStyle test strips are available with just a \$10 copay. These benefits are available to all members, including those on the STAR HSA Plan - even before the deductible. [See all your diabetes management benefits](#)

Dual Insurance Coverage?

Double coverage doesn't always make financial sense. PEHP processes the claim as primary and applies any copay, coinsurance, and deductible amounts, then pays up to the remaining member responsibility after the primary insurance has paid.

» PEHP specialist Taylor Hooton



PREPARE FOR CHANGES IN JULY

We're replacing our claims payment system and member portal. **You will be moved to the new system in July 2025.**



As part of the change, you're getting a new PEHP ID Card to use on July 1

Use this checklist to help you get ready!

- ☐ **April/May: Verify Contact Info**
Log in to your current PEHP account and verify we have your correct contact information. *Under Account-->Update Contact Information.*
- ☐ **June: New PEHP ID Card Mailed/Emailed**
Keep an eye out for your new PEHP ID Card in the mail. *Don't use the new ID card until July 1.*
- ☐ **June 30: Last Day to Use Old ID Card**
This is the last day to use your old PEHP ID card with number "174100" when you visit doctors, dentists, and pharmacies.
- ☐ **July 1: Start Using New PEHP ID Card/Number**
Use your new card/number starting with "M000" on July 1 when you visit doctors, dentists, and pharmacies to avoid any issues with claims. Covered family members can use the same card/number.
- ☐ **July 1-31: Create New Member Account**
Create new account to access benefits, claims, find providers & costs, or add/remove dependents based on midyear life changes. [See helpful guides and videos.](#)
- ☐ **Claims Prior to July 1**
To view claims prior to July 1, log in to the Classic Portal using your old username and password.

Learn more at www.pehp.org/newaccount

Weber State University Benefits Guide

EFFECTIVE: JULY 1, 2025–JUNE 30, 2026
OPEN ENROLLMENT: APRIL 7–MAY 7, 2025

PEHP Medical Per Pay Period Rates

	Employee		Single University		Totals		Employee		Employee +1 University		Totals		Employee		Employee +2 University		Totals	
	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26
Traditional																		
Advantage (HIC)	39.23	41.43	353.05	377.86	392.28	419.29	80.88	85.43	727.91	778.02	808.79	863.45	107.97	114.06	971.74	1037.01	1079.71	1151.07
Summit	39.23	41.43	353.05	365.02	392.28	406.45	80.88	85.43	727.91	751.64	808.79	837.07	107.97	114.06	971.74	1001.85	1079.71	1115.91
Star/HSA																		
Advantage	0	3.00	316.05	334.03	316.05	337.03	0	6.00	664.66	702.15	664.66	708.15	0	8.00	909.58	958.77	909.58	966.77
Summit	0	3.00	316.05	324.28	316.05	327.28	0	6.00	664.66	681.61	664.66	687.61	0	8.00	909.58	930.66	909.58	938.66
HSA Contribution	0	0	33.09	33.09	33.09	33.09	0	0	66.18	66.18	66.18	66.18	0	0	66.18	66.18	66.18	66.18

EMI Dental Per Pay Period Rates

	Employee		Single University		Totals		Employee		Employee +1 University		Totals		Employee		Employee +2 University		Totals	
	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26
Current ASO Rate																		
3.05 PEPM	3.15	3.24	14.34	14.77	17.49	18.01	5.60	5.77	25.50	26.26	31.10	32.03	10.35	10.66	47.11	48.52	57.46	59.18
Renewal ASO Rate																		
3.05 PEPM	3.15	3.24	14.34	14.77	17.49	18.01	5.60	5.77	25.50	26.26	31.10	32.03	10.35	10.66	47.11	48.52	57.46	59.18

VSP Vision Per Pay Period Rates

	Single		Employee +1		Employee +2	
	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26
3.10	3.10	3.10	5.90	5.90	9.40	9.40



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 5](#) 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.

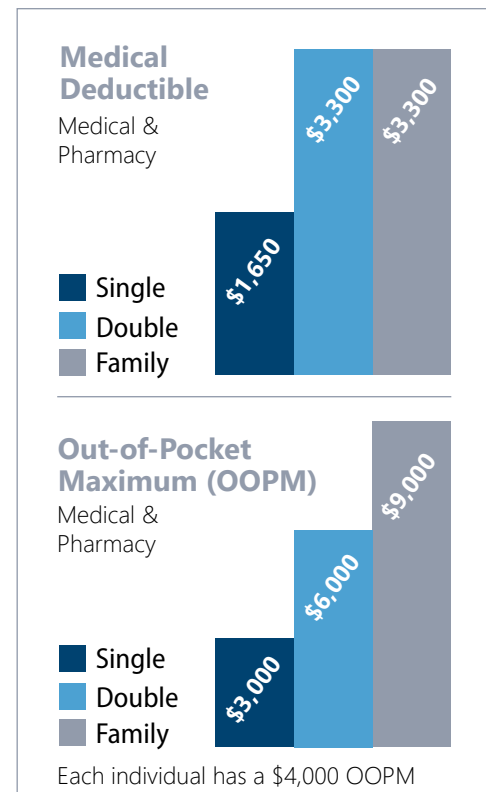
» **STAR HSA Plan:** The OOPM is the most you will pay in a year for covered in-network services. Your OOPM includes what you've paid in your deductible.



STAR HSA 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. [Learn more about HSAs](#)
- » It covers more [preventive services](#) paid at 100%, and certain medications are covered before deductible – including many diabetic supplies, like CGMs, insulin and test strips. See 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. Your family as a whole cannot pay more than \$9,000.
- » Your out-of-pocket maximum includes what you've paid toward your deductible.





Traditional Plans

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.

Medical Deductible

Medical & Pharmacy

**per individual*

■ Single
■ Double
■ Family

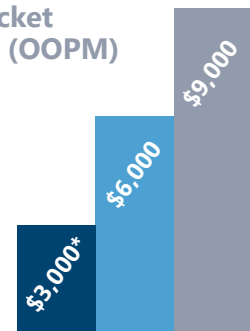


Out-of-Pocket Maximum (OOPM)

Medical & Pharmacy

**per individual*

■ Single
■ Double
■ Family



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.
- » 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.

2025 HSA contribution limits:

Single: \$4,300 (Total from employer + employee)

Double/Family: \$8,550 (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; funds don't carry over from year to year. Eligible FLEX\$ expenses must be incurred between July 1, 2025 and September 15, 2026.
- » You must enroll in FLEX\$ each year during open enrollment to participate.

You can contribute up to \$3,300 in calendar year 2025.

[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>.



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.

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$1,650 Double/family plans: \$3,300 <i>One person or a combination can meet the \$3,300 double/family deductible</i>	
Plan year Out-of-Pocket Maximum	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>	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act <i>Annual physical exam, immunizations. See full list at www.pehp.org/preventiveservices</i>	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers <i>Cash Back opportunities available. Visit www.pehp.org/valueproviders</i>	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits <i>Includes inpatient visits and Autism services</i>	20% after deductible	40% after deductible
Specialist Visits <i>Includes inpatient visits and Autism services</i>	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS** <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org</i>		
30-day Pharmacy <i>Retail only</i>	Tier 1: \$10 co-pay Tier 2: 25% of discounted cost. \$25 minimum, no maximum co-pay Tier 3: 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
90-day Pharmacy <i>Maintenance only</i>	Tier 1: \$20 co-pay Tier 2: 25% of discounted cost. \$50 minimum, no maximum co-pay Tier 3: 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.

**Pharmacy co-pays may be reduced by rebates at point of sale.

Weber State University 2025-26 » Medical Benefits Grid » STAR HSA

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

Weber State University 2025-26 » Medical Benefits Grid » STAR HSA

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
MISCELLANEOUS SERVICES		
Adoption	20% after deductible, up to \$4000 per adoption	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care <i>Up to 10 visits per plan year</i>	20% after deductible	Not covered
Durable Medical Equipment <i>Some DME requires Preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
Home Health/Skilled Nursing <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
Home Hospice	20% after deductible	40% after deductible
Injections <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
Infertility Services/Assisted Reproductive Technology (ART) <i>Diagnostic services only. ART requires preauthorization. Excludes multiple embryo ART implants. See Master Policy for details</i>	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction <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* <i>Balance billing may apply</i>
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible <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>	
Plan year Out-of-Pocket Maximum <i>See 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>	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act <i>Annual physical exam, immunizations. See full list at www.pehp.org/preventiveservices</i>	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers <i>Cash Back opportunities available. Visit www.pehp.org/valueproviders</i>	Starting at \$10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits <i>Includes inpatient visits and Autism services</i>	\$25 co-pay per visit IHC: \$35 co-pay per visit for Summit network University of Utah Medical Group: \$35 co-pay per visit	40% after deductible
Specialist Visits <i>Includes inpatient visits and Autism services</i>	\$35 co-pay per visit IHC: \$45 co-pay per visit for Summit network University of Utah Medical Group: \$45 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	\$35 co-pay per visit	\$35 co-pay per visit
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS** For Drug Tier info, see the Covered Drug List at www.pehp.org		
30-day Pharmacy <i>Retail only</i>	Tier 1: \$10 co-pay Tier 2: 25% of discounted cost. \$25 minimum, no maximum co-pay Tier 3: 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
90-day Pharmacy <i>Maintenance only</i>	Tier 1: \$20 co-pay Tier 2: 25% of discounted cost. \$50 minimum, no maximum co-pay Tier 3: 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.

**Pharmacy co-pays may be reduced by rebates at point of sale.

Weber State University 2025-26 » Medical Benefits Grid » Traditional

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
SPECIALTY DRUGS For Drug Tier info, see the Covered Drug List at www.pehp.org		
Specialty Medications, retail pharmacy <i>Up to 30-day supply</i>	Tier A: 20%. No maximum co-pay Tier B: 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient <i>Up to 30-day supply</i>	Tier A: 20% after deductible. No maximum co-pay Tier B: 30% after deductible. No maximum co-pay	Tier A: 40% after deductible. No maximum co-pay Tier B: 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo <i>Up to 30-day supply</i>	Tier A: 20%. \$150 maximum co-pay Tier B: 30%. \$225 maximum co-pay Tier C1: 10%. No maximum co-pay Tier C2: 20%. No maximum co-pay Tier C3: 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	\$45 co-pay per visit	40% after deductible
Emergency Room <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
Ambulance (ground or air) <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
Physical and Occupational Therapy <i>Outpatient — Up to 20 combined visits per plan year.</i>	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation <i>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
Skilled Nursing Facility and Residential Treatment <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
MISCELLANEOUS SERVICES		
Adoption	20% after deductible, up to \$4000 per adoption	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care <i>Up to 10 visits per plan year</i>	Applicable office co-pay per visit	Not covered
Durable Medical Equipment <i>Some DME requires Preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
Home Health/Skilled Nursing <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
Home Hospice	20% after deductible	40% after deductible
Injections <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
Infertility Services/Assisted Reproductive Technology (ART) <i>Diagnostic Services Only ART requires Preauthorization. Excludes multiple embryo ART implants. See Master Policy for details</i>	20% after deductible per single-embryo ART implant	40% after deductible
Temporomandibular Joint Dysfunction <i>Non-surgical. Up to \$1,000 lifetime maximum</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

Castlevue Hospital

Davis County

Holy Cross Hospital - Davis
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 Medical Center

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

Castlevue Hospital

Davis County

Holy Cross Hospital - Davis
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

Holy Cross Hospital - Jordan Valley
Holy Cross Hospital - Jordan Valley West
Holy Cross Hospital - Salt Lake
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 Medical Center

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

PEHP Wellness Programs

You can earn rebates and win monthly and annual prizes when you participate in some of our programs. Below are some of the programs you can participate in:

- » Biometric Screenings
- » Earn Cash Rebates
- » Diabetes Management
- » Pregnancy Resources
- » Healthy Eating
- » Weight Management
- » Physical Activity
- » Mental & Emotional Well-Being
- » Family & Social Well-Being
- » Financial Wellness
- » Webinars

FOR MORE INFORMATION

PEHP Wellness Programs: 801-366-7300 | 855-366-7300

» E-mail: healthyutah@pehp.org

» Web: www.pehp.org/wellness



Value Added Benefits

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 Discount Program

As a PEHP member, you have access to discounts on many healthy lifestyle products and services through our PEHPplus Discount Program. For example, if cost and quality have been barriers to exploring weight loss treatments, a new partnership with [OrderlyMeds](#) might be right for you. They offer PEHP members up to 10% off on compounded semaglutide, a popular GLP-1 medication. Additionally, you'll receive support for a healthier lifestyle, including a free month of BetterHelp counseling services. .

FOR MORE INFORMATION

» Web: www.pehp.org/pehpplus

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

Childbirth Doula Services

e

Take Control of Your Diabetes

FREE

CGM, Insulin & Coaching



At PEHP, we're proud to support members with diabetes.

- » **No Cost** for **FreeStyle Libre 3 Plus** for real-time glucose insights
- » **No Cost** for **Insulin Lispro** for fast blood sugar control
- » **No Cost** for Online Support & Health Coaching

Learn more: www.pehp.org/diabetes

PEHP Mental Health Care & Services



Visit 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 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.

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 

Public Safety & First Responders



Job-Related Stress? You're Not Alone. There's Help.

If you're a First Responder or work in Public Safety, you have access to PEHP's Expanded Mental Wellness Benefit.

This benefit, available to you and your spouse at no cost, helps address the stress inherent in the workplace by offering counseling services for any reason.

Contact a mental health professional today:

Blomquist Hale: 800-926-9619 | www.blomquisthale.com

Expanded Mental Wellness Benefit

- » Spouses eligible
- » No cost
- » No preauthorization
- » No visit limits



NEW! Cash Back & Copay Map


The smartest path
to care!

Available July 1, 2025

Use these maps to locate **low-cost hospital alternatives** when you need a colonoscopy, surgery, MRI/CT scan, and other procedures.

Treatment Category: Sub-Category:

2 of 5 showing for Bunionectomy or repair of toe deformities (hammertoe, etc.)



Provider	Cash Back
Tanner Clinic - Layton	\$375
West Point Medical Center	\$375
West Point Medical Center - Layton	\$375
West Point Medical Center - Ogden	\$375

Copay Map (Traditional Plan)
Pay no more than \$45 for eligible services.

Cash Back Map (High-Deductible Plan)
Get up to \$3,900 cash back for eligible services.

Log in to your PEHP account
and look for them under the Find Providers & Costs menu.

Find the best care for you

Find and Compare Providers



You can search for doctors in your network based on specialty, name, or location. The tool also provides reviews and additional details to help you make an informed decision.

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.

Compare Prescription Costs



You’ll see medication prices from different pharmacies, including home delivery, which is often less expensive.

Cash Back/Copay Maps



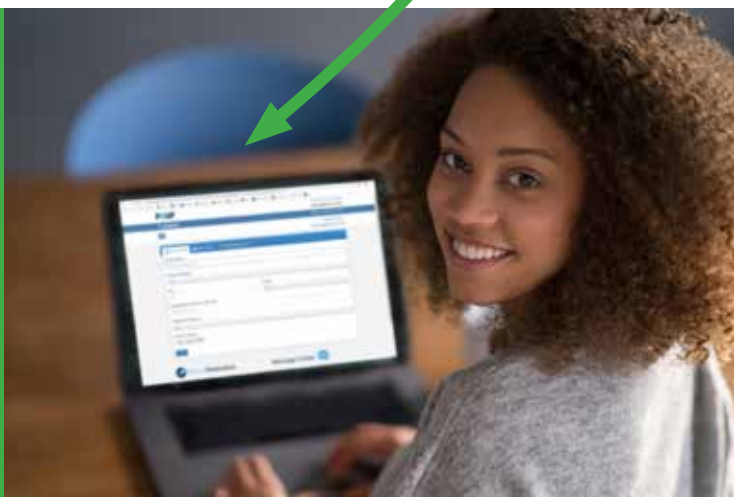
(Available July 1)

This is the best tool to use when you are considering surgery, CT scans, MRIs, colonoscopies and more.

Log in to your PEHP account and look for them under the Find Providers & Costs menu.

These tools are just one way we make life easier for our members.

Start using them today to find the best value!





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

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. 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.

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.
6. Coverage will be terminated if determined by PEHP that the Employee or family Member has committed any

of the following: fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA 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 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:

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

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

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 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.