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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$600** person/**$1,200** family for network providers. **$1,200** person/**$2,400** family for out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Some network provider visits or preventive care received from network providers are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,500** person/**$6,750** family for network providers. **$9,000** person/**$14,000** family for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare this plan doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pehp.org or call 1-800-765-7347 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% of Allowed Amount (AA) after deductible/visit PEHP e-Care: $10 co-pay per visit PEHP Value Clinics: $10 co-pay	60% of Allowed Amount (AA) after deductible	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.
	Specialist visit	40% of AA after deductible	60% of AA after deductible	
	Preventive care/ screening/immunization	No charge	60% of AA after deductible	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% of AA after deductible	60% of AA after deductible	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires pre-authorization. *Some scans require pre-authorization.
	Imaging (CT/PET scans, MRIs)	40% of AA after deductible	60% of AA after deductible	
If you need drugs to treat your illness or condition, more information about prescription drug coverage is available at www.optumrx.com.	Generic drugs (Tier 1) *Cost is per prescription*	Copay (Day Supply) $10 (Retail 1-30; Retail 31-90; Mail up to 90)	Not covered	Generic Policy - Dispense As Written (DAW): If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. Step Therapy Program: Certain medications may be subject to step therapy. You could be asked to try one of the first or second level options before certain drugs are covered by the plan. High Dollar Claim Review, Prior Authorization and Appeals program (HDCR): Medication costs exceeding $1,000 per 30-day supply and $3,000 per 90-day supply require prior authorization. Low Clinical Value Drug List (LCV): Separate formulary exclusion list including low clinical value drugs, me too/chemically similar drugs, new to market drugs, and non-essential.
	Brand Formulary (Tier 2) *Cost is per prescription*	Copay (Day Supply) $30 (Retail 1-30) $60 (Retail 31-90; Mail up to 90)	Not covered	
	Brand/Non-Formulary (Tier 3) *Cost is per prescription*	Copay (Day Supply) $50 (Retail 1-30) $150 (Retail 31-90; Mail up to 90)	Not covered	

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition, more information about prescription drug coverage is available at www.optumrx.com.	Specialty drugs (Tier 4) *Cost is per prescription*	$100 (Generic, Preferred Brand and Non-Preferred Brand)	Not covered	*Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through OptumRX specialty pharmacy by calling OptumRX at 1.800.850.9122. Some exceptions apply. These medications are limited to a 1-30 day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-insurance as listed below. OptumRX Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% of AA after deductible	60% of AA after deductible	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require pre-authorization.
	Physician/surgeon fees	40% of AA after deductible	60% of AA after deductible	
If you need immediate medical attention	Emergency room care	$250 co-pay/visit	$250 co-pay/visit	---None---
	Emergency medical transportation	40% of AA after deductible	40% of AA after deductible	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	Urgent care	$50 co-pay/visit	$100 co-pay after deductible, then plan pays 100% of billed amount	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 co-pay after deductible, then 40% of AA	60% of AA after deductible	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of network inpatient, out-of-state inpatient and some in-network facilities require pre-authorization.
	Physician/surgeon fee	40% of AA after deductible	60% of AA after deductible	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	40% of AA after deductible	60% of AA after deductible	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies, no out of network coverage. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	$300 co-pay after deductible, then 40% of AA	60% of AA after deductible	

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge after deductible	No charge after deductible	---None---
	Childbirth/delivery professional services	40% of AA after deductible	60% of AA after deductible	
	Childbirth/delivery facility services	40% of AA after deductible	60% of AA after deductible	
If you need help recovering or have other special health needs	Home health care	40% of AA after deductible	60% of AA after deductible	*Out-of-network requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year.
	Rehabilitation services	40% of AA after deductible	60% of AA after deductible	*Outpatient Physical Therapy (PT) is limited to 40 combined visits per plan year. Occupational Therapy (OT) and Speech Therapy (ST) are limited to 20 visits per plan year, per therapy class. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation requires pre-authorization.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	40% of AA after deductible	60% of AA after deductible	*No coverage for custodial care.
	Durable medical equipment	40% of AA after deductible	60% of AA after deductible	*Sleep disorder supplies are limited to $325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires pre-authorization.
	Hospice service	40% of AA after deductible	60% of AA after deductible	---None---
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: 40% of AA after deductible per visit.	Not covered	*One routine exam per plan year ages 3-5 as allowed under the Affordable Care Act payable at 100% for network providers.
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Bariatric surgery
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Dental care (Adults or children)• Developmental delay — screening
- Foot care — routine
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances
- Non-emergency care when traveling outside the U.S.
- Nursing — private duty
- Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines
- Office visits — in conjunction with hearing aids; charges for after hours or holiday
- Weight-loss programs

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

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

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

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

Does this Coverage Provide Minimum Essential Coverage? Yes.

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

Does this Coverage Meet the Minimum Value Standard? Yes.

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$600
Specialist copayment	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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

Total Example Cost	**$7,600**

In this example, Peg would pay:

Cost sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,400**

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

The plan's overall deductible	$600
Specialist copayment	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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

Total Example Cost	**$5,500**

In this example, Joe would pay:

Cost sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$1,960
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,560**

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

The plan's overall deductible	$600
Specialist copayment	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$760
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,360**

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

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