

New Hire Guide

South Jordan City

Look inside for important information about how to use your PEHP benefits.



PROUDLY SERVING UTAH PUBLIC EMPLOYEES

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2016-17 Premiums

City of South Jordan Benefit Bi-Weekly Rates | 2016-17 FY

2016-17 Bi-Weekly Rates

Tier 3 [Hired after July 1, 2014]

	Single			Double			Family		
	<u>Single Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>	<u>Double Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>	<u>Family Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>
Advantage/Summit	245.68	196.54	49.14	508.54	406.83	101.71	687.88	550.30	137.58
STAR Advantage/Summit	194.46	175.01	19.45	402.51	362.26	40.25	544.46	490.01	54.45
Dental (Preferred)	21.85	17.48	4.37	29.88	23.90	5.98	45.22	36.18	9.04
Vision (No Employer Contribution/Voluntary)									
	Single			Double			Family		
	<u>Single Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>	<u>Double Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>	<u>Family Cost</u>	<u>City Pays</u>	<u>EE cost per PP</u>
Opticare (Hardware Only)	2.95	0.00	2.95	4.48	0.00	4.48	6.30	0.00	6.30
EyeMed (Exam + Hardware)	3.48	0.00	3.48	5.70	0.00	5.70	7.91	0.00	7.91

Cash-Out Option - Monthly Payment (Proof of Insurance Required)

Medical	Dental:	Medical & Dental
\$319.00	\$30.00	\$349.00

City Paid Benefits/No Cost to Employee

PEHP Life Insurance	City Cost Bi-Weekly
Employee [100,000 Basic]	\$ 5.63
Employee [100,000 Accidental Death & Dismemberment]	\$ 1.70
Spouse [10,000 Basic]	\$ 0.42
Child(ren) [10,000 Basic]	\$ 0.48
Blomquist Hale Employee Assistance Program	
Employee & Dependents	\$ 1.62
Total:	\$ 9.85

Benefit Changes

- » **PEHP E-Care & Value Clinics**
PEHP recently added two value options – Amwell as an E-Care provider, and access to PEHP Value Clinics. Visit www.pehp.org for more information.
- » **Chiropractic Out-of-Network Coverage**
Beginning July 1, 2016 chiropractic services will no longer be covered for out-of-network providers. This is in an effort to help manage costs and quality for chiropractic services. Members can visit www.pehp.org to find participating providers. Members can also nominate a provider to be added as in-network if they are not listed as a participating provider on the provider directory.
- » **Autism Spectrum Disorder Benefit**
PEHP added Autism Spectrum Disorder coverage. Please contact PEHP for information regarding which autism spectrum disorder services are covered.

Reminder

- » **Medicare Supplement**
As a reminder, all of PEHP's prescription drug plans are creditable. PEHP's Medicare Part D Prescription Drug Plans are creditable.
- » **Pharmacy**
PEHP's Preferred Drug List is modified periodically with changes based on recommendations from PEHP's Pharmacy and Therapeutics Committee.
- » **Message Center**
Visit the Message Center at www.pehp.org. This tool allows PEHP to send announcements, messages, and forms that directly relate to our members' needs and concerns.
- » **PEHP Treatment Advisor**
This innovative online tool helps you understand your treatment options, based on clinical evidence, patient satisfaction, and your personal preferences.

Eligibility & Enrollment

Eligibility

All full-time employees are eligible for insurance benefits. Legally married spouses and any children under the age of 26 with whom you have a legal parental relationship are eligible for coverage.

Enrollment

You have 60 days from your hire date to enroll yourself and your eligible dependents for coverage at www.pehp.org. All information gathered or contained through online enrollment is incorporated into the Master Policy. Once you enroll online your coverage will be effective on your hire date. Premiums will be deducted from your paycheck for coverage back to your hire date. If you fail to enroll within 60 days from your hire date* you cannot enroll for coverage until the next annual enrollment period.

Special Enrollment/Mid-Year Events

If you miss the initial 60-day period to enroll, you are not eligible to enroll until the City's next annual open enrollment period unless you meet one of the conditions for Special Enrollment. Special Enrollment allows late enrollees to enroll or drop coverage with PEHP prior to the City's next annual enrollment by meeting one of the following special enrollment/mid-year events:

1. Birth, adoption or placement
2. Marriage
3. Divorce
4. Death

5. Gain or loss of employment of a spouse or dependent
6. Loss or gain of coverage during a spouse's or dependent's open enrollment window.
7. Significant increase or decrease in premium or coverage through a spouse's employer plan, e.g., reduction in working hours that would result in higher premiums or loss of coverage.
8. Involuntary loss of coverage.
9. Work Schedule – a reduction or increase in hours of employment by the employee, spouse, or dependent, which causes a change in the health benefits or employee premium/rate share available to the covered individual, including, but not limited to, a switch between part-time and full-time, a strike or lock out, or commencement or return from an unpaid leave of absence.

Eligible employees will have 60-days from the date coverage is lost or the date of the special enrollment/mid-year event to make the enrollment change. Coverage will be retroactive back to date of event.

Proof of loss of the other coverage must be submitted to PEHP at the time of the enrollment change. Other eligible documentation such as proof of loss of other coverage, copy of marriage, birth or death certificate, divorce decree signed by the judge, adoption or placement papers or other legal documentation required to substantiate the event must be submitted to PEHP. Claims will not be paid until premiums are collected back to the date of event.

Eligibility & Enrollment (continued)

Legal Guardianship

You may enroll any dependent children who are under age 19 who are placed under your legal guardianship within 60-days of receiving legal guardianship. Proof of legal guardianship must be provided to PEHP prior to any benefits being paid under the plan.

Married Dependents

Dependent children can remain covered under the medical and dental plans up to age 26 even if they are married. Life and AD&D plans are not offered to any married child. If your dependent child becomes married during the plan year you must provide a copy of the marriage certificate and notify PEHP immediately.

Personal Online Account

No more paper! By going to www.pehp.org and logging into your personal online account you can:

- » enroll in medical/dental/life/accident
- » enroll in Flex
- » enroll in HSA
- » change HSA contributions
- » add dependents
- » make changes to your benefits
- » change your beneficiary information
- » update your address

Medical Benefits: Traditional



Traditional Option 1

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.

YOU PAY

Summit & Advantage	In-Network Provider	Out-of-Network Provider*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible <i>Applies to out-of-pocket maximum</i>	\$250 per individual, \$500 per family	
Plan year Out-of-Pocket Maximum**	\$3,000 per individual, \$6,000 per family	
INPATIENT FACILITY SERVICES		
Medical and Surgical <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible.
Skilled Nursing Facility <i>Non-custodial Up to 60 days per plan year. Requires preauthorization</i>	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Hospice <i>Up to 6 months in a 3-year period. Requires preauthorization</i>	No charge	30% of In-Network Rate after deductible
Rehabilitation <i>Requires preauthorization</i>	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>Requires preauthorization</i>	10% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Ambulance (ground or air) <i>Medical emergencies only, as determined by PEHP</i>	20% of In-Network Rate after deductible	
Emergency Room <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	\$75 co-pay per visit	\$75 co-pay per visit, plus any balance billing above In-Network Rate
Urgent Care Facility	\$35 co-pay per visit	30% of In-Network Rate after deductible
University of Utah Medical Group Urgent Care <i>Preferred only</i>	\$50 co-pay per visit	Not applicable
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	No charge	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350, when the only services performed are diagnostic testing</i>	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy <i>Outpatient – up to 20 combined visits per plan year. No Preauthorization required</i>	Applicable office co-pay per visit	30% of In-Network Rate after deductible

*You pay 20% of In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They 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.

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

Medical Benefits: Traditional

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	Applicable office co-pay per visit	30% of In-Network Rate after deductible
Surgery and Anesthesia	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
PEHP e-Care <i>Amwell</i>	Medical: \$10 co-pay per visit. Mental Health: Standard benefits apply. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	\$10 co-pay per visit	Not applicable
Primary Care Office Visits and Office Surgeries	\$15 co-pay per visit	30% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	\$25 co-pay per visit	30% of In-Network Rate after deductible
University of Utah Medical Group <i>Preferred only</i>	\$50 co-pay per visit	Not applicable
Emergency Room Specialist Visits	\$25 co-pay per visit	\$25 co-pay per visit, plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays, Minor <i>For each test allowing \$350 or less</i>	No charge	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major <i>For each test allowing more than \$350</i>	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	Outpatient: Applicable office co-pay per visit. Inpatient: 10% of In-Network Rate after deductible	Not covered
PRESCRIPTION DRUGS		
30-day Pharmacy <i>Retail only</i>	Tier 1: \$10 co-pay Tier 2: 25% of discounted cost, \$25 minimum / \$75 maximum Tier 3: 50% of discounted cost, \$50 minimum / \$100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance
90-day Pharmacy <i>Maintenance only</i>	Tier 1: \$20 co-pay Tier 2: 25% of discounted cost, \$50 minimum / \$150 maximum Tier 3: 50% of discounted cost, \$100 minimum / \$200 maximum	Not covered
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 the discounted cost, minus the preferred co-pay. Member pays any balance
Specialty Medications, office/outpatient <i>Up to 30-day supply</i>	Tier A: 20% of In-Network Rate after deductible. No maximum co-pay Tier B: 30% of In-Network Rate after deductible. No maximum co-pay	Tier A: 40% of In-Network Rate after deductible. No maximum co-pay Tier B: 50% of In-Network Rate after deductible. No maximum co-pay
Specialty Medications, through specialty vendor Accredo <i>Up to 30-day supply</i>	Tier A: 20%. \$150 maximum co-pay Tier B: 30%. \$225 maximum co-pay Tier C: 20%. No maximum co-pay	Not covered

Medical Benefits: Traditional

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption <i>See limitations</i>	No charge, plan pays up to \$4,000 per adoption	
Affordable Care Act Preventive Services <i>See Master Policy for complete list</i>	No charge	30% of In-Network Rate after deductible
Allergy Serum	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Chiropractic Care <i>Up to 20 visits per plan year</i>	Applicable office co-pay per visit	Not covered
Dental Accident	10% of In-Network Rate after deductible	10% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME <i>Except for oxygen and Sleep Disorder Equipment, DME over \$750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See the Master Policy for benefit limits</i>	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Medical Supplies	20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Home Health/Skilled Nursing <i>Up to 60 visits per plan year. Requires preauthorization</i>	No charge	30% of In-Network Rate after deductible
Infertility Services** <i>Select services only. See Master Policy for details</i>	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections <i>Requires preauthorization if over \$750</i>	Under \$50: No charge Over \$50: 20% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction** <i>Up to \$1,000 Lifetime Maximum</i>	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible

Medical Benefits: STAR



STAR Option 1

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.

YOU PAY

Summit & Advantage	In-Network Provider	Out-of-Network Provider*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible <i>Applies to out-of-pocket maximum</i>	\$1,300 per single, \$2,600 per family	
Plan year Out-of-Pocket Maximum	\$2,600 per single, \$5,200 per family	
INPATIENT FACILITY SERVICES		
Medical and Surgical <i>All-out-of-network facilities and some in-network facilities require preauthorization. See the Master Policy for details</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Skilled Nursing Facility <i>Non-custodial Up to 60 days per plan year. Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Hospice <i>Up to 6 months in a 3-year period. Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Rehabilitation <i>Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>Requires preauthorization</i>	20% of In-Network Rate after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgery	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Ambulance (ground or air) <i>Medical emergencies only, as determined by PEHP</i>	20% of In-Network Rate after deductible	
Emergency Room <i>Medical emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will apply</i>	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible plus any balance billing above In-Network Rate
Urgent Care Facility	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chemotherapy, Radiation, and Dialysis	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible. Dialysis requires preauthorization
Physical and Occupational Therapy <i>Outpatient – up to 20 combined visits per plan year. No Preauthorization required</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible

*You pay 20% of In-Network Rate after Out-of-Pocket Maximum is met for **Out-of-Network Providers**. They 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.

Medical Benefits: STAR

	In-Network Provider	Out-of-Network Provider*
PROFESSIONAL SERVICES		
Inpatient Physician Office Visits	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PEHP e-Care <i>Amwell</i>	Medical: \$10 co-pay per visit after deductible. Mental Health: Standard benefits apply after deductible. See PEHP Value Options benefits page for details	Not applicable
PEHP Value Clinics	Medical: 20% of In-Network Rate after deductible	Not applicable
Primary Care Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Emergency Room Specialist Visits	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Diagnostic Tests, X-rays	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Mental Health and Substance Abuse <i>No preauthorization required for outpatient service. Inpatient services require preauthorization</i>	20% of In-Network Rate after deductible	Not covered
PRESCRIPTION DRUGS		
30-day Pharmacy <i>Retail only</i>	Tier 1: \$10 co-pay Tier 2: 25% of discounted cost, \$25 minimum / \$75 maximum Tier 3: 50% of discounted cost, \$50 minimum / \$100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay. Member pays any balance
90-day Pharmacy <i>Maintenance only</i>	Tier 1: \$20 co-pay Tier 2: 25% of discounted cost, \$50 minimum / \$150 maximum Tier 3: 50% of discounted cost, \$100 minimum / \$200 maximum	Not covered
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 the discounted cost, minus the preferred co-pay. Member pays any balance
Specialty Medications, office/outpatient <i>Up to 30-day supply</i>	Tier A: 20% of In-Network Rate. No maximum co-pay Tier B: 30% of In-Network Rate. No maximum co-pay	Tier A: 40% of In-Network Rate. No maximum co-pay Tier B: 50% of In-Network Rate. No maximum co-pay
Specialty Medications, through specialty vendor Accredo <i>Up to 30-day supply</i>	Tier A: 20%. \$150 maximum co-pay Tier B: 30%. \$225 maximum co-pay Tier C: 20%. No maximum co-pay	Not covered

Medical Benefits: STAR

	In-Network Provider	Out-of-Network Provider*
MISCELLANEOUS SERVICES		
Adoption <i>See limitations</i>	20% after deductible, plan pays up to \$4,000 per adoption	
Affordable Care Act Preventive Services <i>See Master Policy for complete list</i>	No charge	40% of In-Network Rate after deductible
Allergy Serum	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Chiropractic Care <i>Up to 20 visits per plan year</i>	20% of In-Network Rate after deductible	Not covered
Dental Accident	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
Durable Medical Equipment, DME <i>Except for oxygen and Sleep Disorder Equipment, DME over \$750, rentals that exceed 60 days, or as indicated in Appendix A of the Summary require preauthorization. Maximum limits apply on many items. See Master Policy for benefit limits</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Medical Supplies	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Home Health/Skilled Nursing <i>Up to 60 visits per plan year. Requires preauthorization</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Infertility Services <i>Select services only. See Master Policy for details</i>	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Injections <i>Requires preauthorization if over \$750</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Temporomandibular Joint Dysfunction <i>Up to \$1,000 Lifetime Maximum</i>	50% of In-Network Rate after deductible	50% of In-Network Rate after deductible

Preventive Benefits

Don't put off that test or immunization. Preventive benefits are covered at no cost to you when you see a contracted provider — even before you meet your deductible. This applies to both The STAR Plan and Traditional plan.

Covered Preventive Services for Adults

(Ages 18 and older)

- » Preventive physical exam visits for adults, one time per plan year including:
 - › Blood pressure screening
 - › Basic/comprehensive metabolic panel
 - › Complete blood count
 - › Urinalysis
- » Abdominal aortic aneurysm one-time screening for men aged 65-75 who have ever smoked.
- » Alcohol misuse screening and counseling.
- » Aspirin use for men ages 45-79 and women ages 55-79, covered under the pharmacy benefit when prescribed by a physician.
- » Cholesterol screening for adults of certain ages or at higher risk.
- » Colorectal cancer screening for adults ages 50 to 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy. *Conscious (moderate) Sedation, a type of anesthesia, along with Monitored Anesthesia Care (MAC), is included in standard colonoscopy and is not reimbursed separately, as it's included in the payment to the rendering Physician. General Anesthesia or MAC done by any Provider other than the rendering Physician must be Medically Necessary and requires Preauthorization through PEHP.*
- » Depression screening for adults.
- » Type 2 diabetes screening for adults with high blood pressure.
- » Diet counseling for adults at higher risk for chronic disease including hyperlipidemia, obesity, diabetes, and cardiovascular disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists including registered dietitians.
- » HIV screening for all adults at higher risk.
- » Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - › Hepatitis A
 - › Hepatitis B
 - › Herpes zoster (shingles age 60 and above)
 - › Human papillomavirus (HPV)

- › males age 9-21 Gardasil
- › females age 9-26 Gardasil or Cervarix
- › Influenza (flu shot)
- › Measles, mumps, rubella
- › Meningococcal (meningitis)
- › Pneumococcal (pneumonia)
- › Tetanus, diphtheria, pertussis (Td or Tdap)
- › Varicella (chickenpox)

Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.

- » Obesity screening and counseling for all adults by primary care clinicians to promote sustained weight loss for obese adults.
- » Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- » Tobacco use screening for all adults and cessation interventions for tobacco users.
- » Syphilis screening for all adults at higher risk.

Covered Preventive Services Specifically for Women, Including Pregnant Women

- » Preventive gynecological exam, two per plan year.
- » Anemia screening on a routine basis for pregnant women.
- » Bacteriuria urinary tract or other infection screening for pregnant women.
- » BRCA counseling about genetic testing for women at higher risk.
- » BRCA testing for women at higher risk, requires preauthorization from PEHP.
- » Breast cancer mammography screenings one time per plan year for women over 40.
- » Breast cancer chemoprevention counseling for women at higher risk.
- » Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
- » Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. *Coverage allows for either a manual or electric breast pump within 12 months after delivery. Hospital grade breast pumps when*

medically necessary and preauthorized by PEHP are also included.

- » Cervical cancer screening (pap smear) for women ages 21-65.
- » Chlamydia infection screening for younger women and other women at higher risk.
- » Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
 - › Covered services/devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphragms, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
- » Domestic and interpersonal violence screening and counseling for all women.
- » Folic acid supplements for women who may become pregnant, covered under the pharmacy benefit when prescribed by a physician.
- » Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- » Gonorrhea screening for all women at higher risk.
- » Hepatitis B screening for pregnant women at their first prenatal visit.
- » Human immunodeficiency virus (HIV) screening and counseling for sexually active women.
- » Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older in conjunction with cervical cancer screening (pap smear).
- » Osteoporosis screening for women over age 60 depending on risk factors.
- » Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- » Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.

Continued on back

Preventive Benefits

Continued from front

- » Sexually transmitted infections (STI) counseling for sexually active women.
- » Syphilis screening for all pregnant women or other women at increased risk.

Covered Preventive Services Specifically for Children

(Younger than age 18)

- » Preventive physical exam visits throughout childhood as recommended by the American Academy of Pediatrics including:
 - › Behavioral assessments for children of all ages;
 - › Blood pressure screening for children;
 - › Developmental screening for children under age 3 and surveillance throughout childhood;
 - › Oral health risk assessment for young children;
- » Alcohol and drug use assessments for adolescents.
- » Autism screening for children at 18 and 24 months.
- » Cervical dysplasia (pap smear) screening for sexually active females.
- » Congenital hypothyroidism screening for newborns.
- » Depression screening for adolescents.
- » Dyslipidemia screening for children at higher risk of lipid disorders.
- » Fluoride chemoprevention supplements for children without fluoride in their water source.
- » Gonorrhea preventive medication for the eyes of all newborns.
- » Hearing screening for all newborns, birth to 90 days old.
- » Height, weight, and body mass index measurements for children.
- » Hematocrit or hemoglobin screening for children.
- » Hemoglobinopathies or sickle cell screening for newborns.
- » HIV screening for adolescents at higher risk.
- » Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - › Diphtheria, tetanus, pertussis (Dtap);
 - › Haemophilus influenzae type b (Hib);
 - › Hepatitis A;
 - › Hepatitis B;
 - › Human papillomavirus (HPV);
 - » Males age 9-21 Gardasil;
 - » Females age 9-26 Gardasil or Cervarix;
 - › Inactivated poliovirus;
 - › Influenza (Flu Shot);
 - › Measles, mumps, rubella;
 - › Meningococcal (meningitis);
 - › Pneumococcal (pneumonia);
 - › Rotavirus;
 - › Varicella (chickenpox).

Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.

- » Iron supplements for children ages 6 to 12 months at risk for anemia.
- » Lead screening for children at risk of exposure.
- » Obesity screening and counseling.
- » Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- » Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- » Tuberculin testing for children at higher risk of tuberculosis.
- » Vision screening for all children one time between ages 3 and 5.

Coverage for Specific Drugs

- Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over-the-counter purchases are not covered. See applicable Benefits Summary for coverage information.
- » Aspirin use for men age 45-79 and women age 55-79.
 - » Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
 - » Folic acid supplements for women who may become pregnant.
 - » Fluoride chemoprevention supplements for children without fluoride in their water source.
 - » Iron supplements for children ages 6 to 12 months at risk for anemia.
 - » Tobacco use cessation interventions, up to the maximum approved dose and duration per plan year.

Additional Preventive Services When Enrolled in The STAR Plan

Adults

- » Eye exam, routine. One per plan year.
- » Glaucoma screening.
- » Glucose test.
- » Hearing exam.
- » Hypothyroidism screening.
- » Phenylketones test.
- » Prostate cancer screening.
- » PSA (prostate specific antigen) screening.
- » Refraction exams.
- » Blood typing for pregnant women.
- » Rubella screening for all women of child bearing age at their first clinical encounter.

Children

- » Eye exam, routine. One per plan year.
- » Glaucoma screening.
- » Hearing exam.
- » Hypothyroidism screening.
- » Refraction exams.

PEHP processes claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost-sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness, or condition, diagnostic screening, cost sharing may apply. Certain screening services such as a colonoscopy or mammogram may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

Dental Benefits

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

Preferred Dental Care	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	\$1,500	\$1,500
DIAGNOSTIC	YOU PAY	YOU PAY
Periodic Oral Examinations	No Charge	20% of In-Network Rate
X-rays	20% of In-Network Rate	40% of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	20% of In-Network Rate	40% of In-Network Rate
Sealants Permanent molars only through age 17	20% of In-Network Rate	40% of In-Network Rate
RESTORATIVE		
Amalgam Restoration	20% of In-Network Rate	40% of In-Network Rate
Composite Restoration	20% of In-Network Rate	40% of In-Network Rate
ENDODONTICS		
Pulpotomy	20% of In-Network Rate	40% of In-Network Rate
Root Canal	20% of In-Network Rate	40% of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	40% of In-Network Rate
ORAL SURGERY		
Extractions	20% of In-Network Rate	40% of In-Network Rate
ANESTHESIA General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	20% of In-Network Rate	40% of In-Network Rate

Prosthodontic, implant, and orthodontic services below are not eligible for six months from the date coverage begins unless prior, continuous dental coverage can be shown

PROSTHODONTIC BENEFITS Preauthorization may be required		
Crowns	50% of In-Network Rate	70% of In-Network Rate
Bridges	50% of In-Network Rate	70% of In-Network Rate
Dentures (partial)	50% of In-Network Rate	70% of In-Network Rate
Dentures (full)	50% of In-Network Rate	70% of In-Network Rate
IMPLANTS		
All related services	50% of In-Network Rate	70% of In-Network Rate
ORTHODONTIC BENEFITS 6-month Waiting Period		
Maximum Lifetime Benefit per Member	\$1,500	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum	

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

PEHP Cost & Quality Tools

Shop, Compare, and Save Money on Healthcare! » As a PEHP member, you have access to powerful cost transparency tools to find the best care and value. Log in today and take the mystery out of healthcare pricing.

Treatment Cost Calculator

Are you expecting a baby, do you need surgery, are you managing a chronic condition? The cost calculator has price estimates for more than 300 procedures. Compare expected costs among providers. Customized estimates are based on your benefits.

Provider Costs

Transparency starts with when you search for a doctor. Use our provider costs tool to find healthcare providers in your network. It's more than just a simple provider search. Get cost information, reviews from other PEHP members, cautionary notes from PEHP, and more.

Price a Medication

Price medications and see the sometimes-dramatic cost differences among equivalent drugs, based on your specific benefits.

Cost-Saving Tips

Check often for tips to save money and avoid unexpected bills.



Find these innovative tools

at PEHP for Members at www.pehp.org. Find them under the Cost & Quality Tools logo in the bottom left of the page.

PEHP Online Tools

Personal Online Account

WWW.PEHP.ORG

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

- » Enroll.
- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, by plan, and by date range.
- » Get important plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Cut down on clutter by opting into paperless delivery of Explanations of Benefits (EOBs). Opt to receive EOBs by e-mail, rather than paper form through regular mail, and you'll get an e-mail every time a new one is available at myPEHP.
- » Let us know if you change your mailing address.

Find a Provider

WWW.PEHP.ORG

Looking for a provider, clinic, or facility that is in-network with your plan? Go online to search for providers by name, by specialty, or by location.

Express Scripts Pharmacy

WWW.EXPRESS-SCRIPTS.COM

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

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

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



Medical Networks

PEHP Advantage

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

PARTICIPATING HOSPITALS

Beaver County

Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County

Bear River Valley Hospital

Cache County

Logan Regional Hospital

Carbon County

Castleview Hospital

Davis County

Davis Hospital

Duchesne County

Uintah Basin Medical Center

Garfield County

Garfield Memorial Hospital

Grand County

Moab Regional Hospital

Iron County

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

Salt Lake County (cont.)

The Orthopedic Specialty Hospital (TOSH)
LDS Hospital
Primary Children's Medical Center
Riverton Hospital

San Juan County

Blue Mountain Hospital
San Juan Hospital

Sanpete County

Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County

Sevier Valley 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
Utah Valley Hospital

Wasatch County

Heber Valley Medical Center

Washington County

Dixie Regional Medical Center

Weber County

McKay-Dee Hospital

PEHP Summit

The PEHP Summit network of providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 40 participating hospitals and more than 7,500 participating providers.

PARTICIPATING HOSPITALS

Beaver County

Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County

Bear River Valley Hospital
Brigham City Community Hospital

Cache County

Logan Regional Hospital

Carbon County

Castleview Hospital

Davis County

Lakeview Hospital
Davis Hospital

Duchesne County

Uintah Basin Medical Center

Garfield County

Garfield Memorial Hospital

Grand County

Moab Regional Hospital

Iron County

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

Salt Lake County (cont.)

Jordan Valley Hospital - West
Lone Peak Hospital
Primary Children's Medical Center
Riverton Children's Unit
St. Marks Hospital
Salt Lake Regional Medical Center
University of Utah Hospital
University Orthopaedic Center

San Juan County

Blue Mountain Hospital
San Juan Hospital

Sanpete County

Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County

Sevier Valley Hospital

Summit County

Park City Medical Center

Tooele County

Mountain West Medical Center

Uintah County

Ashley Valley Medical Center

Utah County

Mountain View Hospital
Timpanogos Regional Hospital
Mountain Point Medical Center

Wasatch County

Heber Valley Medical Center

Washington County

Dixie Regional Medical Center

Weber County

Ogden Regional Medical Center

Find Participating Providers

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

PEHP Value Clinics

MEDICAL

The STAR Plan » 25% discount on what you would normally pay an in-network provider

Traditional Plan » \$10 office co-pay

SALT LAKE CITY

[Health Clinics of Utah](#)

168 N 1950 W, Ste. 201 | **801-715-3500**

[Midtown Clinic](#)

230 South 500 East, Suite 510 | **801-320-5660**

[RC Willey Employee Clinic](#)

2301 South 300 West | **801-464-7900**

[WesTech Wellness Center](#)

3605 S West Temple | **801-441-1002**

NORTH SALT LAKE

[Orbit Employee Clinic](#)

845 Overland St. | **801-951-5888**

[FJM Clinic](#)

31 N Redwood Rd, Suite 2 | **801-624-1634**

CLEARFIELD

[Futura Onsite Clinic](#)

11 H Street | **801-774-3265**

LAYTON

[Onsite Care at Davis Hospital](#)

1580 W. Antelope Dr., Suite 110 | **801-807-7699**

OGDEN

[Health Clinics of Utah](#)

2540 Washington Blvd., Ste. 122 | **801-626-3670**

[FJM Clinic](#)

1104 Country Hills Dr., Ste. 110 | **801-624-1633**

PROVO

[Health Clinics of Utah](#)

150 E Center St., Ste. 1100 | **801-374-7011**

OREM

[Blendtec Health and Wellness Clinic](#)

1206 S 1680 W | **801-225-1281**

LEHI

[OnSite Care at Mountain Point Medical](#)

3000 Triumph Blvd, Ste. 320 | **801-753-4600**

DENTAL

10% discount on what you would normally pay an in-network provider.

SALT LAKE CITY

[Family Dental Plan](#)

168 N 1950 W, Ste. 202 | **801-715-3400**

OGDEN

[Family Dental Plan](#)

950 25th Street, #A | **801-395-7090**

ST. GEORGE

[Family Dental Plan](#)

321 N Mall Drive, Ste. M101 | **435-652-3806**



Check with your employer to see which medical and dental plans are available to you. You must be enrolled in an active PEHP medical plan to visit a medical clinic. You must be enrolled in an active PEHP dental plan to visit a dental clinic.

Autism Spectrum Disorder Benefit

A brief overview of PEHP's Autism Spectrum Disorder coverage »

Children ages 2-9 (stops on 10th birthday) are eligible for the benefit, which covers up to 600 hours per year of behavioral health treatment.

- » Therapeutic care includes services provided by speech therapists, occupational therapists, or physical therapists.
- » Please call PEHP (801-366-7555 or 800-765-7347) for information about which autism spectrum disorders and services are covered.
- » Eligible Autism Spectrum Disorder services do not accrue separately, and are subject to the medical plan's visit limits, regular cost sharing limitations – deductibles, co-payments, and coinsurance – and would apply to the out-of-pocket maximum.
- » Mental health services require Preauthorization.
- » No benefits for services received from out-of-network Providers. List of in-network providers is available at PEHP for Members at www.pehp.org or by calling PEHP (801-366-7555 or 800-765-7347).



Amwell On-Demand Doctors

A Faster, Easier Way to See a Doctor » See a doctor via mobile or web. It's available 24 hours a day, every day, and you don't need an appointment. Use Amwell for fevers, ear infections, cold, flu, allergies, migraines, pinkeye, stomach pain, and much more.

If You're on a Traditional Plan

Each on-demand doctor consultation costs only a **\$10 co-pay**.

If You're on The STAR Plan

Each on-demand doctor consultation costs only **\$40** before you meet your deductible. After your deductible is met, you pay only **\$10**. As a limited offer, Amwell consultations will cost only **\$10**, even before you meet your deductible.

Just enter PEHP10 at the payment menu to get that price.

To Get PEHP's Lower Pricing

1. Go to www.amwell.com or download the app (available at iTunes and Google Play Store).
2. Choose "PEHP" as your health insurance.
3. Enter your subscriber ID. Find it on your benefits card. Or log in to PEHP for Members and go to "See What I'm Enrolled In" in the "my Benefits" menu.
4. Find the service key field and enter "PEHP" if you're on the Traditional Plan or "PEHPSTAR" if you're on The STAR Plan.



Limited-Time Special for The STAR Plan:

For a limited time, **Amwell consultations cost only \$10!** Just enter PEHP10 at the payment menu. During the special offer period your deductible isn't automatically credited the \$10 co-pay. If you want to apply the co-pay toward your limits, email publications@pehp.org to get the form.

Guide to PEHP Life & Accident

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

COVERAGE	AMOUNT
Up to Age 70	100,000
Age 71 to 75	50,000
Age 76 and over	25,000



LINE-OF-DUTY DEATH BENEFIT

If you're enrolled in basic coverage, you get an additional \$50,000 Line-of-Duty Death Benefit at no extra cost. Enrollment is automatic.

ACCIDENTAL DEATH RIDER

If you're enrolled in basic coverage, you get an additional \$10,000 Accidental Death Benefit, subject to the provisions of the PEHP Group Accident Plan, at no extra cost. Enrollment is automatic.

EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

- » You want more coverage than the guaranteed issue;
- » You apply for any amount of coverage 60 days after your hire date.

After you apply for coverage, PEHP will guide you through the necessary steps to get evidence of insurability. They may include:

- » Completing a health questionnaire;
- » Basic biometric testing and blood work;
- » Furnishing your medical records.

EMPLOYEE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date, you can purchase up to \$150,000 as guaranteed issue. After 60 days, or for coverage greater than \$150,000 you must provide evidence of insurability.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.28	2.52	5.00	7.52	10.04	12.56	15.08	17.52	20.04	22.52	25.04
Age 30 to 35	1.36	2.68	5.36	8.00	10.68	13.36	16.04	18.68	21.36	24.00	26.68
Age 36 to 40	1.92	3.76	7.56	11.32	15.08	18.88	22.64	26.40	30.20	33.96	37.72
Age 41 to 45	2.32	4.60	9.24	13.84	18.48	23.08	27.72	32.28	36.92	41.52	46.12
Age 46 to 50	4.36	8.76	17.52	26.24	35.00	43.76	52.48	61.24	70.00	78.72	87.48
Age 51 to 55	5.24	10.52	21.00	31.48	42.00	52.48	63.00	73.48	84.00	94.48	105.00
Age 56 to 60	8.36	16.76	33.52	50.32	67.08	83.84	100.60	117.36	134.16	150.92	167.68
Age 61 to 70	14.20	28.44	56.88	85.28	113.72	142.16	170.60	199.04	227.48	255.88	284.32
After age 70, rates remain constant and coverage changes											
Coverage Amounts	14.20	28.44	56.88	85.28	113.72	142.16	170.60	199.04	227.48	255.88	284.32
Age 71 to 75	12,500	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	6,250	12,500	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life & Accident

SPOUSE BASIC COVERAGE: Your employer funds \$10,000 of spouse basic coverage at no charge to you.

SPOUSE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date or date of marriage, you can purchase up to \$50,000 as guaranteed issue for your spouse. After 60 days, or for coverage greater than \$50,000 you will need evidence of insurability.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.28	2.52	5.00	7.52	10.04	12.56	15.08	17.52	20.04	22.52	25.04
Age 30 to 35	1.36	2.68	5.36	8.00	10.68	13.36	16.04	18.68	21.36	24.00	26.68
Age 36 to 40	1.92	3.76	7.56	11.32	15.08	18.88	22.64	26.40	30.20	33.96	37.72
Age 41 to 45	2.32	4.60	9.24	13.84	18.48	23.08	27.72	32.28	36.92	41.52	46.12
Age 46 to 50	4.36	8.76	17.52	26.24	35.00	43.76	52.48	61.24	70.00	78.72	87.48
Age 51 to 55	5.24	10.52	21.00	31.48	42.00	52.48	63.00	73.48	84.00	94.48	105.00
Age 56 to 60	8.36	16.76	33.52	50.32	67.08	83.84	100.60	117.36	134.16	150.92	167.68
Age 61 to 70	14.20	28.44	56.88	85.28	113.72	142.16	170.60	199.04	227.48	255.88	284.32
After age 70, rates remain constant and coverage changes											
Coverage Amounts	14.20	28.44	56.88	85.28	113.72	142.16	170.60	199.04	227.48	255.88	284.32
Age 71 to 75	12,500	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 76 and over	6,250	12,500	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

Your employer funds \$10,000 of dependent children coverage at no charge to you. If you apply within 60 days of your hire date, you can buy additional coverage. After 60 days, any new application for coverage, or increase in coverage, will require evidence of insurability. All eligible children will be covered at the same level.

CHILD BASIC COVERAGE: Your employer funds \$10,000 at no cost to you.

Coverage Amount	10,000	15,000
Monthly cost	0	0.52

Accidental Death and Dismemberment (AD&D)

AD&D provides benefits for death, loss of use of limbs, speech, hearing or eye sight due to an accident, subject to the limitations of the policy.

INDIVIDUAL PLAN

Your employer funds \$100,000 of AD&D coverage at no charge to you. Select additional coverage from \$25,000 to \$150,000 for a maximum coverage of \$250,000.

Employee's Coverage Amount	Individual Plan	Family Plan
	Monthly Cost	Monthly Cost
100,000	0	1.28

FAMILY PLAN

» Upgrade your individual AD&D plan to a family plan. Convert your employee-funded \$100,000 individual plan to a \$100,000 family plan at a cost of 1.28 per month.

- » Select a coverage amount ranging from \$25,000 to \$150,000, and your spouse and dependents will be automatically covered as follows:
 - » Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;
 - » Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.
- » If injury to an insured person covered for this benefit results within one year of the date of the accident in any of the losses set forth, the plan will pay the sum specified opposite such loss, but the total amount payable for all such losses as a result of any one accident will not exceed the Principal Sum applicable to the insured person. The Principal Sum applicable to the insured person is the amount specified on the enrollment form.

PEHP Life & Accident

Accidental Death and Dismemberment (AD&D)

Additional AD&D Coverage and Cost

Coverage Amount	INDIVIDUAL PLAN			FAMILY PLAN		
	Bi-Weekly Cost	Semi-Monthly Cost	Monthly Cost	Bi-Weekly Cost	Semi-Monthly Cost	Monthly Cost
25,000	0.43	0.46	0.92	0.58	0.62	1.24
50,000	0.85	0.92	1.84	1.14	1.24	2.48
75,000	1.28	1.38	2.76	1.72	1.86	3.72
100,000	1.69	1.84	3.68	2.28	2.48	4.96
125,000	2.12	2.30	4.60	2.85	3.10	6.20
150,000	2.54	2.76	5.52	3.42	3.72	7.44

AD&D Payment Schedule

FOR LOSS OF	BENEFIT PAYABLE
Life	Principal Sum
Two Limbs	Principal Sum
Sight of Two Eyes	Principal Sum
Speech and Hearing (both ears)	Principal Sum
One Limb or Sight of One Eye	Half Principal Sum
Speech or Hearing (one ear)	Half Principal Sum
Use of Two Limbs	Principal Sum
Use of One Limb	Half Principal Sum
Thumb and Index Finger On Same Hand	Quarter Principal Sum

LIMITATIONS AND EXCLUSIONS

Refer to the Group Term Life and Accident Plan Master Policy for details on plan limitations and exclusions. Call 801-366-7495 or visit www.pehp.org for details.

Master Policy

This document is a summary only. Find complete terms and conditions in the Master Policy. Find it when you log in to the Members' Section of www.pehp.org. Or, to request a copy, email publications@pehp.org or call the number below.



www.pehp.org
 560 East 200 South
 Salt Lake City, UT 84102-2004
 801-366-7495 | 800-753-7495

Accident Weekly Indemnity

- » Employee coverage only
- » If you enroll in AD&D coverage, you may also purchase Accident Weekly Indemnity coverage, which will provide a weekly income if you are totally disabled due to an accident that is not job-related.
- » The maximum eligible weekly amount is based on your monthly gross salary at the time of enrollment. You may purchase a lower amount of coverage than the eligible monthly gross salary, but may not buy coverage for more than the eligible monthly gross salary.

Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	BI-WEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
250 and under	25	0.12	0.14	0.28
251 to 599	50	0.24	0.26	0.52
600 to 700	75	0.35	0.38	0.76
701 to 875	100	0.46	0.50	1.00
876 to 1,050	125	0.58	0.64	1.28
1,051 to 1,200	150	0.70	0.76	1.52
1,201 to 1,450	175	0.81	0.88	1.76
1,451 to 1,600	200	0.93	1.02	2.04
1,601 to 1,800	225	1.04	1.14	2.28
1,801 to 2,164	250	1.16	1.26	2.52
2,165 to 2,499	300	1.39	1.50	3.02
2,500 to 2,899	350	1.62	1.76	3.52
2,900 to 3,599	400	1.86	2.02	4.04
3,600 and over	500	2.32	2.52	5.04

Accident Medical Expense

- » Employee coverage only
- » This benefit is available to help you pay for medical expenses that are in excess of those covered by all group insurance plans and no-fault automobile insurance.
- » This benefit will provide up to \$2,500 to help cover medical expenses incurred due to an accident that is not job-related.

Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	BI-WEEKLY COST	SEMI-MONTHLY COST	MONTHLY COST
\$ 2,500	\$ 0.38	\$ 0.42	\$ 0.84

Vision Benefits: EyeMed



PEHP LGRP Full (Plan H)

Additional discounts

40% OFF

Complete pair of prescription eyeglasses

20% OFF

Non-prescription sunglasses

20% OFF

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilatation as Necessary	\$10 Co-pay	Up to \$30
Retinal Imaging	Up to \$39	N/A
Frames	\$0 Co-pay, \$100 Allowance, 20% off balance over \$100	Up to \$50
Standard Plastic Lenses		
Single Vision	\$10 Co-pay	Up to \$25
Bifocal	\$10 Co-pay	Up to \$40
Trifocal	\$10 Co-pay	Up to \$55
Lenticular	\$10 Co-pay	Up to \$55
Standard Progressive Lens	\$75	Up to \$40
Premium Progressive Lens ^A	\$95 - \$120	
Tier 1	\$95	Up to \$40
Tier 2	\$105	Up to \$40
Tier 3	\$120	Up to \$40
Tier 4	\$75, 80% of charge less \$120 Allowance	Up to \$40
Lens Options		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate—Adults	\$40	N/A
Standard Polycarbonate—Kids under 19	\$40	N/A
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating ^A	\$57-\$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$75	N/A
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to \$55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	\$0 Co-pay, \$120 Allowance, 15% off balance over \$120	Up to \$96
Disposable	\$0 Co-pay, \$120 Allowance; plus balance over \$120	Up to \$96
Medically Necessary	\$0 Co-pay, paid-in-full	Up to \$200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Premiums—monthly		
Single	\$7.53	
Double	\$12.34	
Family	\$17.13	

Benefits are not provided from services or materials arising from: Orthopedic or vision training, subnormal vision aids and any associated supplemental testing, Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures, Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same Benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. ^APremium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

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Vision Benefits: Opticare



Opticare Plan: 120C

Plan **120C Eyewear Only**-(No eye exam, hardware only benefit)

	<u>Hardware Only</u>
Single	\$ 6.39
Two Party	\$ 9.70
Family	\$13.66

LGRP	Select Network	Broad Network	Out-of-network
Eye Exam * (10-120C Plan ONLY)			
Eyeglass exam	\$10 Co-pay	\$15 Co-pay	◆\$40 Allowance
Contact exam	\$10 Co-pay	\$15 Co-pay	◆\$40 Allowance
Dilation	100% Covered	Retail	Included above
Contact Fitting	100% Covered	Retail	Included above
Plastic Lenses (10-120C/120C)			
Single Vision	100% Covered	\$10 Co-pay	◆\$85 Allowance
Bifocal (FT 28)	100% Covered	\$10 Co-pay	for lenses,
Trifocal (FT 7x28)	100% Covered	\$10 Co-pay	options,
			and coatings
Lens Options (10-120C/120C)			
Progressive (Standard plastic no-line)	\$30 Co-pay	\$50 Co-pay	
Premium Progressive Options	20% Discount	No Discount	
Glass lenses	15% Discount	15% Discount	
Polycarbonate	\$40 Co-pay	25% Discount	
High Index	\$80 Co-pay	25% Discount	
Coatings (10-120C/120C)			
Scratch Resistant Coating	100% Covered	\$10 Co-pay	
Ultra Violet protection	100% Covered	\$10 Co-pay	
Other Options	Up to 25%	Up to 25%	
<i>A/R, edge polish, tints, mirrors, etc.</i>	Discount	Discount	
Frames (10-120C/120C)			
Allowance Based on Retail Pricing	\$120 Allowance	\$100 Allowance	◆\$80 Allowance
Add'l Eyewear (10-120C/120C)			
**Additional Pairs of Glasses Throughout the Year	Up to 50% Off Retail	Up to 25% Off Retail	
Contacts (10-120C/120C)			
<i>Contact benefits is in lieu Of lens and frame benefit.</i>	\$120 Allowance	\$100 Allowance	◆\$80 Allowance
Additional contact purchases:			
***Conventional	Up to 20% off	Retail	
***Disposables	Up to 10% off	Retail	
Frequency (10/120C/120C)			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
LASIK Benefit (10-120C/120C)			
LASIK	\$750 Off Per Eye	Not Covered	Not Covered

Discounts

Any item listed as a discount is a merchandise discount only and not an insured benefit. Discounts vary by providers, see provider for details

** 50% discount varies by provider, ask provider for details.

*** Must purchase full year supply to receive discounts on select brands. See provider for details.

**** LASIK (Refractive surgery) Standard Optical Locations ONLY. LASIK services are not an insured benefit – this is a discount only.

All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.

◆ **Out of Network** – Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.

For more Information please visit www.opticareofutah.com or call 800-363-0950

PEHP FLEX\$

Time to Get Serious About Reducing Out-of-Pocket Costs »

At open enrollment, you agree to set aside a portion of your pre-tax salary for the year to pay eligible expenses. PEHP offers two types of FLEX\$: healthcare and dependent day care. Enroll in one or both.

Plan Year Contribution Limits

- » Up to \$2,550 for healthcare expenses
(May adjust annually for inflation)
- » Up to \$5,000 for dependent day care expenses (you and your spouse combined)

How Your Contribute

- » Your contributions are withheld from your paycheck pre-tax. The total amount you contribute is evenly divided among pay periods.
- » The total amount you choose to withhold for healthcare expenses is immediately available as soon as you begin FLEX\$.

You Can't Have an HSA

You can't contribute to a health savings account (HSA) while you're enrolled in healthcare FLEX\$. However, you may have a dependent day care FLEX\$ and/or a limited FSA and contribute to an HSA.

Rollover Funds

Now you can carry over up to \$500 in your healthcare FLEX\$ from one plan year to the next. However, because of this change, you no longer have a grace period for eligible expenses.

FLEX\$ Timeline

Eligible FLEX\$ expenses must be incurred between Jan. 1, 2016, and Dec. 31, 2016. You must submit claims by March 31, 2017. You can carry over up to \$500 in your healthcare FLEX\$ into the next plan year.

Learn More

Contact PEHP FLEX\$: 801-366-7503 or 800-753-7703; email: flex@pehp.org. See instructions below to download the PEHP FLEX\$ brochure or email publications@pehp.org to request a copy.



Enroll for FLEX\$ at PEHP for Members at www.pehp.org during open enrollment. For more information about FLEX\$, such as eligible expenses and detailed terms and conditions, read the FLEX\$ Brochure and FLEX\$ Handbook. Find them in the "Benefits Information Library" under the "my Benefits" after you log in to your online personal account.

Know Before You Go

Tools Help You Choose a Doctor and Understand Your Treatment »

Don't leave your family's health and finances to chance! PEHP gives you tools and information to be an informed healthcare consumer. Go to [PEHP for Members](#) and know before you go!

Step 1 » Use the **Treatment Advisor** to learn more about your condition and treatment options, and learn questions to ask your doctor.

Step 2 » Use the **Treatment Cost Calculator** to estimate the cost of your treatment and compare cost differences among providers.

Step 3 » Determine if **PEHP Value Options**, including Amwell On-Demand Doctors and PEHP Value Clinics, can treat your condition or provide a starting point.

Step 4 » Use PEHP's **Find and Select a Provider** to understand potential coverage pitfalls for a particular treatment or provider type, including the need for preauthorization and specific services that may be excluded.

Step 5 » Use PEHP's **Find and Select a Provider** to find a doctor in your network, read about other PEHP members' experiences with him or her, and see notes about any relevant practice patterns or other situations of which you should be aware.

Step 6 » If you still need help figuring out what to do next, call PEHP at 801-366-7555 or 800-765-7347.



Find these innovative tools at PEHP for Members

at www.pehp.org. Look for them under these menus.

my
BENEFITS

↳ Find and Select a Provider

my
MONEY

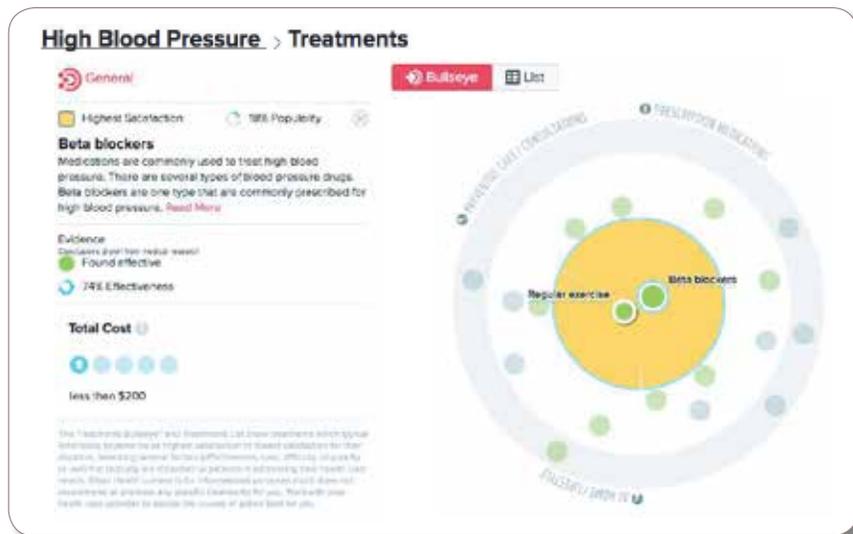
↳ Facility and Treatment Costs
(Treatment Cost Calculator)

my
HEALTH

↳ Find Treatment Options
(Treatment Advisor)

PEHP Treatment Advisor

Empowering Better Healthcare Choices » This innovative online tool helps you understand your treatment options, based on clinical evidence, patient satisfaction, and your personal preferences.



Understand Your Options

This gives you an easy way to see and understand the best options for you. Now you can confidently weigh and discuss your treatment options with your doctor.

Comes Recommended

Most members who try the PEHP Treatment Advisor like it. A recent member survey shows more than 90% would recommend it to a friend.



Use the PEHP Treatment Advisor at any time at PEHP for Members at www.pehp.org. From the PEHP for Members homepage, find the PEHP Treatment Advisor logo at the bottom right. Or, go to the "my Health" menu and click "Learn About My Treatment Options."

PEHP for Members

Manage Your Benefits Online » Get the most from your benefits at PEHP for Members at www.pehp.org. Log in for personalized information and tools. Enroll, find and compare doctors, get cost information, learn benefit details, and more.

my BENEFITS

- Find and Select a Provider
- See Your Claims
- Enroll Online
- Access Plan Information

my MONEY

- See Treatment Costs
- See Facility Costs
- See Medication Costs
- Change HSA Contributions

my HEALTH

- Find Treatment Options
- Healthy Utah Testing
- Get Health Snapshot
- See Treatment Tips



» “You’ve got mail!” We send important information about your benefits and care through the **PEHP Message Center**. You may see vital notices specifically for you, such as cost information about medications you’re taking.

» Encourage your adult dependents (spouses and children 18 years or older) to create their individual PEHP for Members account. This allows them to see their claims, personal biometrics, and personalized messages from PEHP. Call PEHP at 801-366-7555 or 800-765-7347 for instructions.

Find PEHP for Members at www.pehp.org.

To create your online personal account, you’ll need your PEHP ID number and your Social Security number.

Find your PEHP ID number on your benefits card or your EOBs. Or call PEHP at 801-366-7555 or 800-765-7347.



How to Enroll Online at www.pehp.org

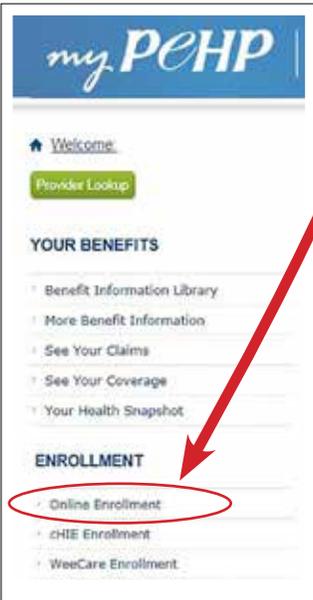
1 Access online enrollment through myPEHP. Go to www.pehp.org and locate the “Member Login” on the left side of the page.

If you’re logging in for the first time, click “Create your personal account.”

Otherwise, enter your user ID and password to access your information.

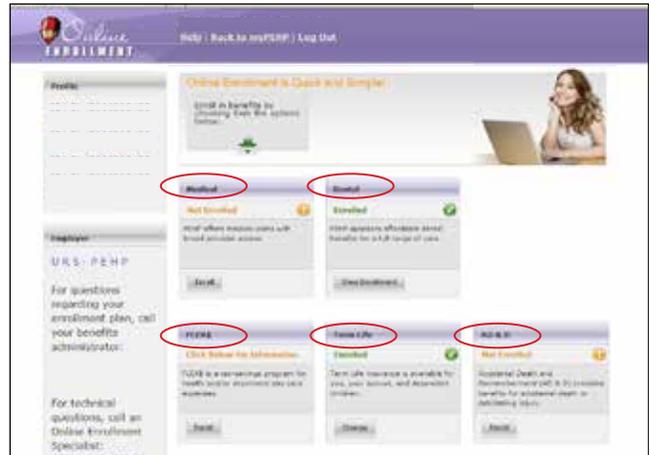


2 At eligible times, you’ll have access to online enrollment through a link on the menu at left.



3 The online enrollment main page shows benefits available to you. Click “Enroll” beneath the desired benefit to begin.

Enroll or make changes in any of the following benefits:
medical, dental,
Term Life,
AD&D, and
FLEX\$.



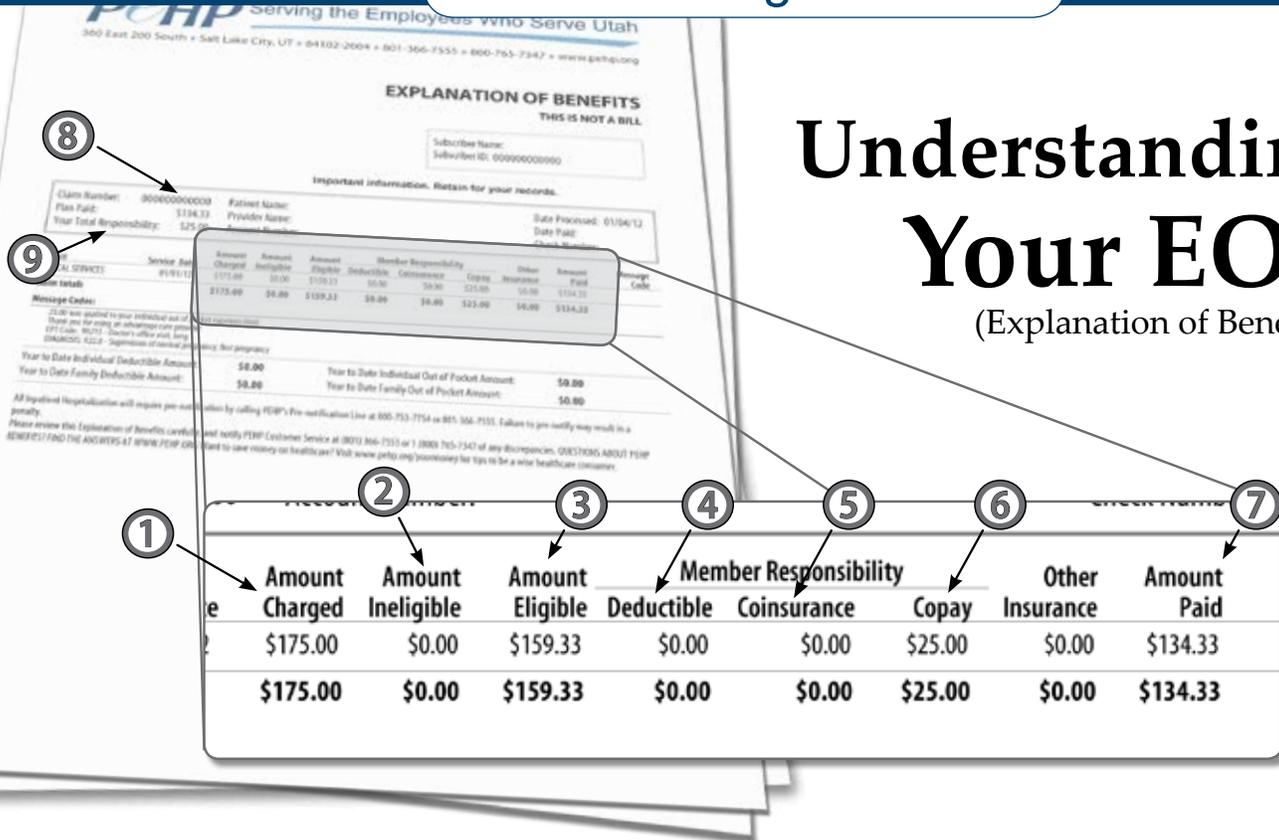
CONTACT PEHP, NOT SOUTH JORDAN CITY, IF YOU HAVE QUESTIONS.

ONLINE ENROLLMENT: 801-366-7410 OR 800-753-7410

LIFE INSURANCE: 801-366-7495 OR 800-753-7495

Understanding Your EOB

(Explanation of Benefits)



We send an EOB each time we process a claim for you or someone on your plan. Go paperless and view EOBs at your myPEHP account at www.pehp.org.

- 1 AMOUNT CHARGED**
The medical provider's (e.g., doctor, hospital, or clinic) bill for your service.
- 2 AMOUNT INELIGIBLE**
The part of the bill that includes services not covered by your plan. Settle this with the provider's office (not PEHP).
- 3 AMOUNT ELIGIBLE**
This is PEHP's In-Network Rate. This is the most we allow in-network providers to charge for this service. However, out-of-network providers may charge more than the In-Network Rate. Avoid paying more by using only in-network providers (find them at www.pehp.org).
- 4 DEDUCTIBLE**
The set amount you pay for eligible charges in a plan year before PEHP benefits fully take effect.

- 5 COINSURANCE**
The percentage of the cost you must pay under your plan. You may already have paid this amount when you received services. If so, the provider's bill may be lower than what's shown on the EOB.

- 6 COPAY**
The fixed dollar amount you must pay under your plan. You may already have paid this amount when you received services. If so, the provider's bill may be lower than what's shown on the EOB.

- 7 AMOUNT PAID**
The part of the bill PEHP paid.

- 8 CLAIM NUMBER**
Keep this number as reference if you call PEHP about your claim.

- 9 YOUR TOTAL RESPONSIBILITY**
The amount of the bill the provider expects you to pay. Settle this with the provider's office (not PEHP).

See your applicable benefit summary and master policy for complete terms of your plan.

Education

Seminars

PEHP Healthy Utah staff offer seminars along the Wasatch Front and St. George area on various health topics.

Webinars

Get connected online with our wellness webinar series. Join us monthly for 30 minutes of useful health information.

Health Challenges

These email based challenges are self paced and can assist you with setting and achieving your health goals. Register online.

For the Worksite

Wellness Council Support & Resources

Comprised of employees from all divisions and levels within an organization, Wellness Councils support employee-focused activities and organizational changes to create a healthy worksite where employees can thrive.



Coaching

PEHP Waist Aweigh

If you have a Body Mass Index of 30+, this program provides education, support, and rebates.

Lighten Up

If you have a BMI of 25+, you qualify for this 8-week class moderated by our Registered Dietitians.

Diabetes & YOU

A 4-week email and webinar based class taught by PEHP Registered Dietitians.

Personal Health Sessions

A 30-minute consultation by phone, email, or in person with a Registered Dietitian.

To learn more about PEHP Wellness services and resources, please visit www.pehp.org and log into your online personal account to view your wellness benefits.

Wellness for You

Know. Plan. Act.



Biometric Screenings

Complete annual biometric testing (cholesterol, blood glucose, body composition, waist circumference, and blood pressure) at a Healthy Utah testing session to earn rebates.

Rebates

Complete the biometric testing and a Health Risk Assessment found at your online personal account to earn your \$50 Know & Plan Rebate. If your measurements fall within predetermined criteria you will earn the \$50 Good For You rebate. Health Improvement Rebates are available if your biometrics don't meet the Good For You criteria. For members with an HSA, rebates will be contributed into your HSA. For members with an FSA, you will receive a check that is taxed.

PEHP WeeCare

WeeCare is PEHP's prenatal and postpartum program, designed to help expectant mothers have a healthy pregnancy, a safe delivery, and a healthy baby. Those with PEHP coverage are eligible to participate. Benefits include free prenatal vitamins, and educational materials on pregnancy, pregnancy-related illnesses, and complications.

Contact Information

MAILING ADDRESS

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

WEBSITES

PEHP www.pehp.org

WeeCare Prenatal Healthcare Program
..... www.pehp.org/weecare

PEHPPlus www.pehp.org/plus

Pharmacy Program — Express Scripts
..... www.express-scripts.com

Out-of-State Provider Listing
..... www.multiplan.com

Health Savings Account
..... www.healthequity.com

TELEPHONE NUMBERS

PEHP Medical & Dental

Enter your PEHP ID or Social Security number for faster service

Customer Service 801-366-7555
Toll Free 800-765-7347

PEHP preauthorization of inpatient facility
..... 801-366-7755
Toll Free 800-753-7754

PEHP preauthorization of inpatient mental health & substance abuse
..... 801-366-7755

PEHP Group Term Life & Accident Plans 801-366-7495

PEHP Flexible Spending and HSA
..... 801-366-7503

PEHP Healthy Utah 801-366-7300
..... or 855-366-7300

PEHP Waist Aweigh 801-366-7300
..... or 855-366-7300

PEHPPlus 801-366-7478
..... or 800-753-7478

PEHP Wee Care 801-366-7400
..... or 855-366-7400

Out-of-State Network 800-922-4362

Prescription Drug Benefits

PEHP Pharmacy Department 801-366-7555
..... or 800-765-7347

Express Scripts 800-903-4725

Specialty Pharmacy

Accredo 800-803-2523

City of South Jordan Human Resources

Debbie 801-253-5203 ext. 1853
Theresa 801-253-5203 ext. 1851
Stacey 801-253-5203 ext. 1854
Chelsea 801-253-5203 ext. 1850
Teresa 801-253-5203 ext. 1852



