**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?** | **$1,500** single/**$3,000** family | 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, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care received from network providers is 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?** | **$4,000** single/**$8,000** family for network providers. Any one individual may not apply more than $7,900 toward the family out-of-pocket limit. | 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, the overall family out-of-pocket limit must be 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 | $25 co-pay after deductible | 20% of Allowed Amount (AA) after deductible | *The following services are not covered: office visits in conjunction with hearing aids; charges for after hours or holiday; testing and treatment for developmental delay. Infertility charges are payable at 50% of allowed amount after deductible, up to $750 per plan year and $5,000 lifetime. |
| | Specialist visit | $35 co-pay after deductible<br>Midtown Clinic/PEHP e-Care: $10 co-pay per visit after deductible | 20% of AA after deductible | |
| | Preventive care/ screening/immunization | No charge | No charge plus any balance billing | *Limited to the Salt Lake City enhanced preventive services. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge after deductible if the Allowed Amount (AA) is under $350, 20% of AA after deductible if AA is over $350 | 20% of AA after deductible | *Attended sleep studies, and any sleep studies done in a facility require pre-authorization and are limited to $2,000 in a 3-year period.<br>*Infertility services are payable at 50% of AA after deductible for eligible services, up to $750 per plan year and $5,000 lifetime.<br>*Genetic testing requires pre-authorization.<br>*Some scans require pre-authorization. |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible if the AA is under $350, 20% of AA after deductible if AA is over $350 | 20% of AA after deductible | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at www.pehp.org. | Generic drugs (Tier 1) | $10 co-pay after deductible/ visit | The preferred co-pay after deductible plus the difference above the discounted cost | *PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or pre-authorization. Enteral formula requires pre-authorization. No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication. |
| | Preferred brand drugs (Tier 2) | 25% of discounted cost after deductible, $25 minimum / $75 maximum | The preferred co-pay after deductible plus the difference above the discounted cost | |
| | Non-preferred brand drugs (Tier 3) | 50% of discounted cost after deductible, $50 minimum / $100 maximum | The preferred co-pay after deductible plus the difference above the discounted cost | |
| | Specialty drugs (Tier 4) | Medical - 20% of AA after deductible for Tier A drugs, 30% of AA after deductible for Tier B drugs | Tier A 40% of AA after deductible<br>Tier B 50% of AA after deductible | *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; pre-authorization may be required. Using Accredo may reduce your cost. |

[* 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% of AA after deductible | 30% of AA after deductible | *No coverage for cosmetic surgery. Payable at 50% of AA after deductible when medically necessary: eligible infertility surgery (up to $750 per plan year and $5,000 lifetime); sclerotherapy of varicose veins; micro-phlebectomy. |
| | Physician/surgeon fees | 10% of AA after deductible | 30% of AA after deductible | |
| **If you need immediate medical attention** | Emergency room care | $150 co-pay after deductible/ visit | $150 co-pay after deductible/visit plus any balance billing | ---None--- |
| | Emergency medical transportation | $50 co-pay after deductible/ occurrence | $50 co-pay after deductible/ occurrence, plus any balance billing | *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 | $45 co-pay after deductible/ visit | 20% of AA after deductible/visit | ---None--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% of AA after deductible | 30% 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 | 10% of AA after deductible | 30% of AA after deductible | |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $35 co-pay after deductible | 30% 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. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling. |
| | Inpatient services | 10% of AA after deductible | 30% of AA after deductible | |
| **If you are pregnant** | Office visits | 10% of AA after deductible | 30% of AA after deductible | *Mother and baby's charges are separate. Cost sharing does not apply to preventive services. |
| | Childbirth/delivery professional services | 10% of AA after deductible | 30% of AA after deductible | |
| | Childbirth/delivery facility services | 10% of AA after deductible | 30% 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 need help recovering or have other special health needs** | Home health care | No charge after deductible | 20% of AA after deductible | *Requires pre-authorization. No coverage for custodial care. Maximum of 60 visits per plan year. |
| | Rehabilitation services | Outpatient: $35 co-pay after deductible/visit<br>Inpatient: 10% after deductible | 20% of AA after deductible | *Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) requires pre-authorization after the initial evaluation, maximum limit of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires pre-authorization. |
| | Habilitation services | Outpatient: $35 co-pay after deductible/visit<br>Inpatient: 10% after deductible | 20% of AA after deductible | |
| | Skilled nursing care | 10% of AA after deductible | 30% of AA after deductible | *Requires pre-authorization. No coverage for custodial care. Maximum of 60 days per plan year. |
| | Durable medical equipment | 20% of AA after deductible | 20% 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 over $750, rentals over 60 days, or as indicated in Appendix A of your Master Policy require pre-authorization. |
| | Hospice service | No charge after deductible | 20% of AA after deductible | ---None--- |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge plus balance billing | *One routine exam per plan year. |
| | Children's glasses | Full charge | Full charge | ---None--- |
| | Children's dental check-up | Full charge | Full charge | ---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.)

- Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations
- Charges for which a third party, auto insurance, or worker's compensation plan are responsible
- Chiropractic care from an out-of-network provider
- Complications from any non-covered services, devices, or medications
- Cosmetic surgery
- Custodial care and/or maintenance therapy
- Developmental delay — testing and treatment
- Foot care — routine
- Glasses
- Hearing aids
- 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
- Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP
- 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.
- Dental care (Adults or children)
- Long-term 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** | $1,500 |
| **Specialist copayment** | $35 |
| **Hospital (facility) coinsurance** | 10% |
| **Other coinsurance** | 10% |

**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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $610 |
| **What isn't covered** | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,110** |

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

| | |
|---|---|
| **The plan's overall deductible** | $1,500 |
| **Specialist copayment** | $35 |
| **Hospital (facility) coinsurance** | 10% |
| **Other coinsurance** | 10% |

**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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $400 |
| **What isn't covered** | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,900** |

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

| | |
|---|---|
| **The plan's overall deductible** | $1,500 |
| **Specialist copayment** | $35 |
| **Hospital (facility) coinsurance** | 10% |
| **Other coinsurance** | 10% |

**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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $100 |
| **What isn't covered** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

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 Salt Lake City Human Resources.

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