

PEHP

COBRA/Retiree

2015-2016

State of Utah COBRA/Retiree Benefits Summary

STATE OF UTAH COBRA/RETIREE

Benefits Summary

Effective July 2015

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This Benefits Summary should be used in conjunction with the PEHP Master Policy. It contains information that only applies to PEHP subscribers who are employed by the State of Utah COBRA/Retiree and their eligible dependents. Members of any other PEHP plan should refer to the applicable publications for their coverage.

It is important to familiarize yourself with the information provided in this Benefits Summary and the PEHP Master Policy to best utilize your medical plan. The Master Policy is available by calling PEHP. You may also view it at www.pehp.org.

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP. The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at www.pehp.org. All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

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Welcome to PEHP

We want to make accessing and understanding your healthcare benefits simple. This Benefits Summary contains important information on how best to use PEHP's comprehensive benefits.

Please contact the following PEHP departments or affiliates if you have questions.

ON THE WEB

»Website www.pehp.org

Create an online personal account at www.pehp.org to review your claims history, receive important information through our Message Center, see a comprehensive list of your coverages, use the Cost & Quality Tools to find providers in your network, access Healthy Utah rebate information, check your FLEX\$ account balance, and more.

CUSTOMER SERVICE

..... 801-366-7555
 or 800-765-7347

Weekdays from 8 a.m. to 5 p.m.

Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

PREAUTHORIZATION

»Inpatient hospital preauthorization..... 801-366-7755
 or 800-753-7754

MENTAL HEALTH/SUBSTANCE ABUSE PREAUTHORIZATION

»PEHP Customer Service.....801-366-7755
 or 800-765-7347

PRESCRIPTION DRUG BENEFITS

»PEHP Customer Service.....801-366-7555
 or 800-765-7347

»Express Scripts..... 800-903-4725
www.express-scripts.com

SPECIALTY PHARMACY

»Accredo..... 800-501-7260

GROUP TERM LIFE AND AD&D

»PEHP Life and AD&D 801-366-7495

HEALTH SAVINGS ACCOUNTS (HSA)

»PEHP FLEX\$ Department 801-366-7503
 or 800-753-7703

»HealthEquity 866-960-8058
 www.healthequity.com/stateofutah

PRENATAL AND POSTPARTUM PROGRAM

» PEHP WeeCare 801-366-7400
 or 855-366-7400
 www.pehp.org/weecare

WELLNESS AND DISEASE MANAGEMENT

» PEHP Healthy Utah 801-366-7300
 or 855-366-7300
 www.healthyyutah.org

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

» PEHP Integrated Care 801-366-7555
 or 800-765-7347

VALUE-ADDED BENEFITS PROGRAM

»PEHPplus www.pehp.org/plus

»Blomquist Hale 800-926-9619
 www.blomquisthale.com

ONLINE ENROLLMENT HELP LINE

..... 801-366-7410
 or 800-753-7410

CLAIMS MAILING ADDRESS

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

Benefit Changes

No Traditional Plan Pharmacy Deductible

Traditional Plan » Starting July 1, 2015, you won't have to meet a deductible on the Traditional Plan to get pharmacy benefits. You'll only have a medical deductible (\$350 individual, \$700 family). Your out-of-pocket maximum (\$3,000 individual, \$6,000 double, \$9,000 family) now will include pharmacy and specialty drugs. This will reduce your risk (the most you would spend) on the Traditional Plan from \$9,350 per person (2014-15 plan year) to \$3,350 per person (2015-16 plan year).

Traditional Plan	2014-15	2015-16
Medical Deductible	\$250/\$500 – not included in medical out-of-pocket maximum	\$350/\$700 – not included in medical out-of-pocket maximum
Pharmacy Deductible	\$100/\$200	\$0
Medical Out-of-Pocket Maximum	\$2,500/\$5,000/\$7,500	\$3,000/\$6,000/\$9,000
Pharmacy Out-of-Pocket Maximum	\$3,000 per person	Included in medical out-of-pocket maximum
Specialty Pharmacy Out-of-Pocket Maximum	\$3,600 per person	Included in medical out-of-pocket maximum
Overall Per-Person Maximum, Including Deductible <i>This limit caps the amount you spend out-of-pocket for any one person on your plan before you meet your family plan limit.</i>	\$9,350 per person	\$3,000 per person after you meet your \$350 individual deductible or your \$700 family deductible

Also

New PEHP Treatment Advisor » This innovative online tool saves you the hassle of scouring the web for information related to your symptoms. Get information here based on your personal treatment preferences and priorities. Compare treatments based on clinical evidence and others' experiences.

PEHP Online Tools

Access Benefits and Claims

WWW.PEHP.ORG

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

- » Receive important messages about your benefits and coverage through our Message Center.
- » See your claims history — including medical, dental, and pharmacy. Search claims histories by member, plan, and date range.
- » Become a savvy consumer using our Cost & Quality Tools.
- » View and print plan documents, such as forms and Master Policies.
- » Get a simple breakdown of the PEHP benefits in which you're enrolled.
- » Track your biometric results and access Healthy Utah rebates and resources.
- » Cut down on clutter by opting in to paperless delivery of explanation of benefits (EOBs). Opt to receive EOBs by email, rather than paper forms through regular mail, and you'll get an email every time a new one is available.
- » Change your mailing address.

Find a Provider

WWW.PEHP.ORG

Looking for a provider, clinic, or facility that is contracted with your plan? Look no farther than www.pehp.org. Go online to search for providers by name, specialty, or location.

Access Your Pharmacy Account

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, co-pays, and cost-saving alternatives.

PEHP Medical Networks

PEHP Advantage

The PEHP Advantage network of contracted 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

Valley View Medical Center

Juab County

Central Valley Medical Center

Kane County

Kane County Hospital

Millard County

Delta Community Medical Center
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 Medical Center

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 Regional Medical Center

Wasatch County

Heber Valley Medical Center

Washington County

Dixie Regional Medical Center

Weber County

McKay-Dee Hospital

PEHP Summit

The PEHP Summit network of contracted Providers consists of predominantly IASIS, MountainStar, and University of Utah hospitals & clinics providers and facilities. It includes 39 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

Valley View Medical Center

Juab County

Central Valley Medical Center

Kane County

Kane County Hospital

Millard County

Delta Community Medical Center
Fillmore Community Hospital

Salt Lake County

Huntsman Cancer Hospital
Jordan Valley Hospital

Salt Lake County (cont.)

Lone Peak Hospital
Pioneer Valley 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 Medical Center

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 (opens soon)

Wasatch County

Heber Valley Medical Center

Washington County

Dixie Regional Medical Center

Weber County

Ogden Regional Medical Center

PEHP Preferred

The PEHP Preferred network of contracted providers consists of providers and facilities in both the Advantage and Summit networks. It includes 46 participating hospitals and more than 12,000 participating providers.

Find Participating Providers

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

Understanding Your Benefits Grid

Traditional Standard Option I
Summit, Advantage & Preferred | In-Network Provider

DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS

Plan Year Deductible <i>Applies to out-of-pocket maximum</i>	← ①	\$250 per individual
Plan year Out-of-Pocket Maximum**	← ②	\$3,000 per individual

INPATIENT FACILITY SERVICES

Medical and Surgical <i>All-out-of-network facilities and some in-network facilities require pre-authorization. See the Master Policy for details</i>	10% of In-Network Rate after deductible
Intensive Care Facility <i>Non-custodial services pre-authorization</i>	10% of In-Network Rate after deductible

OUTPATIENT FACILITY SERVICES

Ambulance (ground or air) <i>Medical necessity only. Not allowed in Utah</i>	10% of In-Network Rate after deductible	30% of In-Network Rate after deductible
Emergency Room <i>Medical emergency only, as determined by PEHP. Authorized separate facility benefit will be applied.</i>	\$75 co-pay per visit	\$75 co-pay per visit, plus any balance billing allowed in Network Rate
Urgent Care Facility	\$45 in-pay per visit	Not applicable
University of Utah Medical Group Urgent Care <i>Network only</i>	\$50 co-pay per visit	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor <i>For each and always \$200 of acts, when the prep services performed are diagnostic testing.</i>	No charge	30% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Major <i>For each act always more than \$550, 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	10% of In-Network Rate after deductible. Dialysis requires pre-authorization
Physical and Occupational Therapy <i>Maximum 12 sessions per year per plan year</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 out 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.

WWW.PEHP.ORG

① MEDICAL DEDUCTIBLE
The set dollar amount you must pay for yourself and/or your family members before PEHP begins to pay for covered medical benefits.

② PLAN YEAR OUT-OF-POCKET MAXIMUM
The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance (and deductibles for STAR plans).

CO-PAYMENT

A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the PEHP In-Network Rate.

IN-NETWORK

In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay any applicable co-payment.

OUT-OF-NETWORK

If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and PEHP's In-Network Rate.

IN-NETWORK RATE

The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the In-Network Rate (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

For more definitions, please see the Master Policy.

Understanding In-Network Providers

State of Utah plans pay limited benefits for out-of-network providers. It's important to understand the difference between in-network and out-of-network providers and how the PEHP In-Network Rate works to avoid unexpected charges.

In-Network Rate

Doctors and facilities in-network with your network — in-network providers — have agreed not to charge more than PEHP's In-Network Rate for specific services. Your benefits are often described as a percentage of the In-Network Rate. With in-network providers, you pay a predictable amount of the bill: the remaining percentage of the In-Network Rate. For example, if PEHP pays your benefit at 80% of In-Network Rate, your portion of the bill generally won't exceed 20% of the In-Network Rate.

Balance Billing

It's a different story with out-of-network providers. They may charge more than the In-Network Rate unless they have an agreement with you not to. These doctors and facilities, who aren't a part of your network, have no pricing agreement with PEHP. The portion of the benefit PEHP pays is based on what we would pay an in-network provider. You could be billed the full amount that the provider charges above the In-Network Rate. This is called "balance billing."

Negotiate a Price

DON'T GET BALANCE BILLED
 Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

Understand that charges to you may be substantial if you see an out-of-network provider. Your plan generally pays a smaller percentage of the In-Network Rate, and you could also be billed for any amount charged above the In-Network Rate.

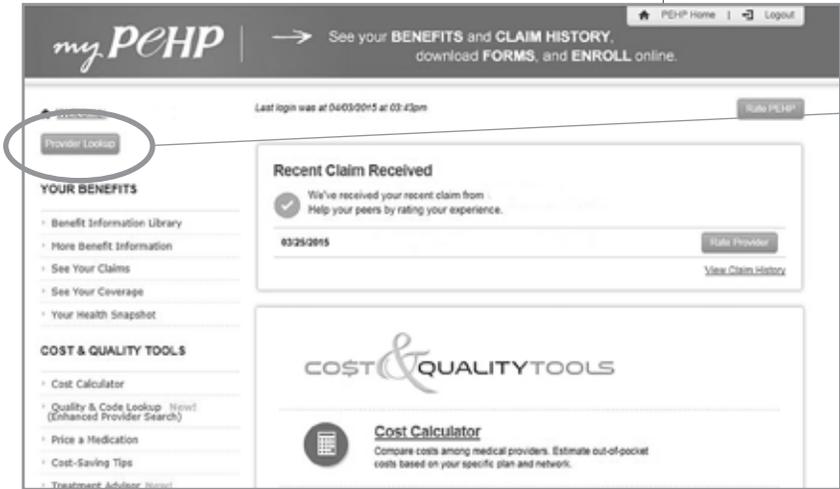
The amount you pay for charges above the In-Network Rate won't apply to your deductible or out-of-pocket maximum.

Consider Your Options

Carefully choose your network based on the group of medical providers you prefer or are more likely to see. See the comparison on Page 6 or go to www.pehp.org to see which network includes your doctors.

Ask questions before you get medical care. Make sure every person and every facility involved is in-network with your plan.

Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.



Go to www.pehp.org, log into your personal online account, and click "Provider Lookup" to find a doctor or facility in-network with your network.

Health Savings Accounts

About Health Savings Account (HSA)

An HSA is a tax-advantaged, interest-bearing account. Your money goes in tax-free, grows tax-free, and can be spent on qualified health expenses tax-free. An HSA can be a great way to save for health expenses in both the short and long term.

An HSA is similar to a flexible spending account; you contribute pre-tax dollars to pay for eligible health expenses.

An HSA has several advantages. You never have to forfeit what you don't spend. Your money carries over from year-to-year and even from employer-to-employer. All the while, an HSA can earn tax-free interest in a savings account.

You can also contribute to an HSA much like you would a 401(k). You decide how many pre-tax dollars you want withheld from each paycheck, and earnings grow tax free.

Eligible HSA expenses include deductibles and coinsurance, as well as health expenses that are eligible to be paid with a medical flexible spending account.

HSA Eligibility

To be eligible for the HSA the following things must apply to you:

- » You're not participating in or covered by a flexible spending account (FSA) or HRA or their balances will be \$0 on or before June 30.
- » You're not covered by another health plan (unless it's another HSA-qualified plan).
- » You're not covered by Medicare or TRICARE.
- » You're not a dependent of another taxpayer.

Banking with HealthEquity

PEHP has an arrangement with HealthEquity to handle your HSA. The COBRA/Retiree will make your HSA contributions through PEHP to HealthEquity into your account. You are responsible for the management of your HSA funds once they are in the account.

For More Information

For more information about HSAs go to:
www.pehp.org/thestarplan,
www.healthequity.com/stateofutah,
www.ustreas.gov, or www.irs.gov.

HSA IRS Limits

2015 HSA IRS limits

Single: \$3,350

Double/Family: \$6,650

55+ Catch-up contribution: \$1,000

The PEHP STAR Plan (HSA-Qualified)

SUMMIT*

ADVANTAGE*

PREFERRED**

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions. * Services received by an out-of-network provider will be paid at a percentage of PEHP's In-Network Rate (In-Network Rate). You will be responsible for your assigned Co-Insurance and deductible (if applicable). You may also be responsible for any amounts billed by an out-of-network provider in excess of PEHP's In-Network Rate. There is no out-of-pocket maximum for services received from an out-of-network provider.

YOU PAY

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible	\$1,500 single plan \$3,000 double or family plan	Same as using an in-network provider *See above for additional Information **See below for additional Information
Plan Year Out-of-Pocket Maximum <i>Includes amounts applied to Deductibles, Co-Insurance and prescription drugs</i>	\$2,500 single plan \$5,000 double plan \$7,500 family plan	No out-of-network out-of-pocket maximum *See above for additional Information **See below for additional Information
Maximum Lifetime Benefit	None	None
**Applicable deductibles and Co-Insurance for services provided by an out-of-network provider will apply to your in-network plan year deductible and out-of-pocket maximum. However, once your in-network deductible and out-of-pocket maximum are met, Co-Insurance amounts for out-of-network providers will still apply.		
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	40% of In-Network Rate after deductible

Out-of-network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
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	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>	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, Minor	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>Requires preauthorization after 12 visits</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
PROFESSIONAL SERVICES		
Inpatient Physician 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
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	20% of In-Network Rate after deductible	20% of In-Network Rate after deductible, plus any balance billing above In-Network Rate
State Health Clinic <i>Members get an extra 25% discount on eligible services before any amounts are applied to the deductible or coinsurance</i>	20% of In-Network Rate after deductible	Not applicable
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 services. Inpatient services require preauthorization</i>	Outpatient: 20% of In-Network Rate after deductible Inpatient: 20% of In-Network Rate after deductible	Outpatient: 40% of In-Network Rate after deductible Inpatient: 40% of In-Network Rate after deductible

Out-of-network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
PRESCRIPTION DRUGS		
Retail Pharmacy <i>Up to 30-day supply</i>	Tier 1: \$10 co-pay after deductible Tier 2: 25% of discounted cost after deductible. \$25 minimum, no maximum co-pay Tier 3: 50% of discounted cost after deductible. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost after deductible, minus the applicable co-pay. Member pays any balance
Mail-Order <i>Some medications available through retail pharmacy at mail-order co-pay</i>	Tier 1: \$20 co-pay after deductible Tier 2: 25% of discounted cost after deductible. \$50 minimum, no maximum co-pay Tier 3: 50% of discounted cost after deductible. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost after deductible, minus the applicable co-pay. Member pays any balance
Specialty Medications, retail pharmacy <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	Plan pays up to the discounted cost after deductible, minus the applicable 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. Tier B: 50% of In-Network Rate after deductible.
Specialty Medications, through specialty vendor Accredo <i>Up to 30-day supply</i>	Tier A: 20% of In-Network Rate after deductible. \$150 maximum co-pay Tier B: 30% of In-Network Rate after deductible. \$225 maximum co-pay Tier C: 20% of In-Network Rate. No maximum co-pay	Not covered
MISCELLANEOUS SERVICES		
Adoption <i>See limitations</i>	No charge after deductible, up to \$4,000 per adoption	No charge after deductible, 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 10 visits per plan year</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
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 Master Policy require preauthorization. Maximum limits apply on many items. See the 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 and Medical Case Management</i>	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Infertility Services <i>Select services only. See the Master Policy</i>	50% of In-Network Rate after deductible	70% 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	70% of In-Network Rate after deductible

Out-of-network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

Getting a Credit After You Reach Your Out-of-Pocket Maximum

Total costs can vary for big-ticket healthcare procedures among Utah hospitals. Here's an example generated by PEHP's Cost Calculator.

Knee replacement - full

	"Hospital A"	"Hospital B"	"Hospital C"	"Hospital D"
▶ TOTAL COST	\$26,190	\$33,390	\$38,035	\$39,808

Below is a list of credits that apply for procedures listed on the next page for the The STAR Plan or Utah Basic Plus on the Summit network.

Facility Name	Credit
Davis Hospital; Jordan Valley Hospital; Pioneer Valley Hospital; Salt Lake Regional Hospital	\$250 credit Your out-of-pocket maximum lowered by \$250

THESE APPLY ONLY WHEN YOU HAVE THE SUMMIT NETWORK

The hospitals below are part of the Summit network but have no credit:

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

Duchesne County

Uintah Basin Medical Center

Garfield County

Garfield Memorial Hospital

Grand County

Moab Regional Hospital

Iron County

Valley View Medical Center

Juab County

Central Valley Medical Center

Kane County

Kane County Hospital

Millard County

Delta Community Medical Center
Fillmore Community Hospital

Salt Lake County

Huntsman Cancer Hospital
Primary Children's Medical Center
Riverton Children's Unit
University Orthopaedic Center
St. Marks Hospital
Lone Peak Hospital
University of Utah Hospital

San Juan County

Blue Mountain Hospital
San Juan Hospital

Sanpete County

Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County

Sevier Valley Medical Center

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

Wasatch County

Heber Valley Medical Center

Washington County

Dixie Regional Medical Center

Weber County

Ogden Regional Medical Center

Applicable Procedures

Inpatient only

BACK

Various spinal fusion surgeries

COLON

Colon surgery

HEART

Carotid endarterectomy with other medical conditions

Valve replacement and repair

Heart bypass (CABG)

Angioplasty (PTCA) with drug-eluting stent

HERNIA

Hernia repair, except inguinal and femoral for adults

HIP

Hip replacement

KNEE

Knee replacement

MASTECTOMY

Total mastectomy for cancer

SHOULDER

Shoulder replacement

Depending on where you choose to have these procedures performed, you may be eligible for a credit toward your out-of-pocket maximum.

To find out if your procedure is eligible, get the five-digit CPT (Current Procedural Technology) code from your doctor and call PEHP. With the information, we can tell you if your procedure may trigger the credit. However, neither we nor the facility can guarantee how the procedure will be billed until after you're discharged. Everything that happens during your inpatient stay affects the final billing. The final billing determines if the procedure is eligible for the credit.

Traditional (Non-HSA)

SUMMIT

ADVANTAGE

PREFERRED

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions. * Services received by an out-of-network provider will be paid at a percentage of PEHP's In-Network Rate (In-Network Rate). You will be responsible for your assigned Co-Insurance and deductible (if applicable). You may also be responsible for any amounts billed by an out-of-network provider in excess of PEHP's In-Network Rate. There is no out-of-pocket maximum for services received from an out-of-network provider.

YOU PAY

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan Year Deductible <i>Not included in the Out-of-Pocket Maximum</i>	\$350 per individual, \$700 per family	Same as using an in-network provider *See above for additional information **See below for additional information
Plan year Out-of-Pocket Maximum <i>Includes amounts applied to Co-Insurance and prescription drugs</i>	\$3,000 per individual \$6,000 per double \$9,000 per family	No out-of-pocket maximum *See above for additional information **See below for additional information
Maximum Lifetime Benefit	None	None
**Applicable deductibles and Co-Insurance for services provided by an out-of-network provider will apply to your in-network plan year deductible and Out-of-Pocket Maximum. However, once your in-network deductible and Out-of-Pocket Maximum are met, Co-Insurance amounts for out-of-network providers will still apply.		
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	40% of In-Network Rate after deductible

Out-of-network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
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	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>	20% of In-Network Rate, minimum \$150 co-pay per visit	20% of In-Network Rate, minimum \$150 co-pay per visit, plus any balance billing above In-Network Rate
Urgent Care Facility	\$45 co-pay per visit Preferred only: University of Utah Medical Group Urgent Care Facility: \$50 co-pay per visit	40% of In-Network Rate after deductible
Diagnostic Tests, X-rays, Minor	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>Requires preauthorization after 12 visits</i>	Applicable office co-pay per visit	40% of In-Network Rate after deductible
PROFESSIONAL SERVICES		
Inpatient Physician Visits	Applicable office co-pay per visit	40% of In-Network Rate after deductible
Surgery and Anesthesia	20% of In-Network Rate after deductible	40% of In-Network Rate after deductible
Primary Care Office Visits and Office Surgeries	\$25 co-pay per visit Preferred only: University of Utah Medical Group Primary Care Office visits: \$50 co-pay per visit	40% of In-Network Rate after deductible
Specialist Office Visits and Office Surgeries,	\$35 co-pay per visit Preferred only: University of Utah Medical Group Specialist Office visit: \$50 co-pay per visit	40% of In-Network Rate after deductible
Emergency Room Specialist	\$35 co-pay per visit	\$35 co-pay per visit, plus any balance billing above In-Network Rate
State Health Clinic	\$10 co-pay per visit	Not applicable
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 services. Inpatient services require preauthorization</i>	Outpatient: \$35 co-pay per visit Inpatient: Applicable office co-pay per visit	Outpatient: 40% of In-Network Rate after deductible Inpatient: 40% of In-Network Rate after deductible

Out-of-Network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

	In-Network Provider	Out-of-Network Provider <i>You may be balance billed. See Page 9 for explanation</i>
PRESCRIPTION DRUGS		
Retail Pharmacy <i>Up to 30-day supply</i>	Tier 1: \$10 co-pay Tier 2: 25% of discounted cost. \$25 minimum, no maximum co-pay Tier 3: 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the applicable co-pay. Member pays any balance
Mail-Order <i>Some medications available through retail pharmacy at mail-order co-pay</i>	Tier 1: \$20 co-pay Tier 2: 25% of discounted cost. \$50 minimum, no maximum co-pay Tier 3: 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the applicable co-pay. Member pays any balance
Specialty Medications, retail pharmacy <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	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. Tier B: 50% of In-Network Rate after deductible.
Specialty Medications, through specialty vendor Accredo <i>Up to 30-day supply</i>	Tier A: 20% of In-Network Rate. \$150 maximum co-pay Tier B: 30% of In-Network Rate. \$225 maximum co-pay Tier C: 20% of In-Network Rate. No maximum co-pay	Not covered
MISCELLANEOUS SERVICES		
Adoption <i>See limitations</i>	No charge after deductible, up to \$4,000 per adoption	No charge after deductible, 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 10 visits per plan year</i>	Applicable office co-pay per visit	40% of In-Network Rate after deductible
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 Master Policy require preauthorization. Maximum limits apply on many items. See the 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 the Master Policy</i>	50% of In-Network Rate after deductible	70% 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	70% of In-Network Rate after deductible

**Some services on your plan are payable at a reduced benefit of 50% of In-Network Rate or 30% of In-Network Rate. These services do not apply to any out-of-pocket maximum. Deductible may apply. Refer to the Master Policy for specific criteria for the benefits listed above, as well as information on limitations and exclusions.

Out-of-network providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. For more details, see Page 11.

Out-of-Pocket Maximum Credit » Traditional » Summit Network

Important Benefit Change After You Reach Your Out-of-Pocket Maximum

Total costs can vary for big-ticket healthcare procedures among Utah hospitals. Here's an example generated by PEHP's Cost Calculator.

Knee replacement - full

	"Hospital A"	"Hospital B"	"Hospital C"	"Hospital D"
▶ TOTAL COST	\$23,504	\$33,016	\$33,739	\$39,808

Below is a list of credits that apply for procedures listed on the next page for the Traditional (non-HSA) Plan on the Summit network.

Facility Name	Credit
Davis Hospital; Jordan Valley Hospital; Pioneer Valley Hospital; Salt Lake Regional Hospital	\$250 credit Your out-of-pocket maximum lowered by \$250

THESE APPLY ONLY WHEN YOU HAVE THE SUMMIT NETWORK

The hospitals below are part of the Summit network but have no credit:

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

Duchesne County

- Uintah Basin Medical Center

Garfield County

- Garfield Memorial Hospital

Grand County

- Moab Regional Hospital

Iron County

- Valley View Medical Center

Juab County

- Central Valley Medical Center

Kane County

- Kane County Hospital

Millard County

- Delta Community Medical Center
- Fillmore Community Hospital

Salt Lake County

- Huntsman Cancer Hospital
- Primary Children's Medical Center
- Riverton Children's Unit
- University Orthopaedic Center
- St. Marks Hospital
- Lone Peak Hospital
- University of Utah Hospital

San Juan County

- Blue Mountain Hospital
- San Juan Hospital

Sanpete County

- Gunnison Valley Hospital
- Sanpete Valley Hospital

Sevier County

- Sevier Valley Medical Center

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

Wasatch County

- Heber Valley Medical Center

Washington County

- Dixie Regional Medical Center

Weber County

- Ogden Regional Medical Center

Wellness and Value-Added Benefits

PEHP Healthy Utah

PEHP Healthy Utah is an exclusive wellness benefit for subscribers and their spouses. It offers a variety of programs, services and resources to help you get and stay well - including cash rebates* for good health and health improvements.

Subscribers and their spouses are eligible to attend one Healthy Utah testing session each plan year free of charge. PEHP Healthy Utah is offered at the discretion of the Employer.

FOR MORE INFORMATION

PEHP Healthy Utah

801-366-7300 | 855-366-7300

» E-mail: healthyutah@pehp.org

» Web: www.healthyutah.org/myhu

PEHP WeeCare

PEHP WeeCare is our prenatal and postpartum program. The purpose of WeeCare is to help expectant mothers have a healthy pregnancy, a safe delivery, and a healthy baby. Those with PEHP coverage are eligible to participate.

Those eligible may enroll at any time during pregnancy through 12 weeks postpartum. WeeCare participants may qualify to receive free prenatal vitamins, educational materials, and cash rebates*.

FOR MORE INFORMATION

PEHP WeeCare

P.O. Box 3503

Salt Lake City, Utah 84110-3503

801-366-7400 | 855-366-7400

» E-mail: weecare@pehp.org

» Web: www.pehp.org/weecare

PEHP Plus

The money-saving program PEHPplus helps promote good health and save you money. It provides savings on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. Learn more at www.pehp.org/plus.

PEHP Waist Aweigh

PEHP Waist Aweigh is a weight management program offered at no extra cost to subscribers and spouses enrolled in a PEHP medical plan. If you have a Body Mass Index (BMI) of 30 or higher, you may qualify. PEHP Waist Aweigh is offered at the discretion of the Employer.

For more information about PEHP Waist Aweigh and to enroll, go to www.pehp.org.

FOR MORE INFORMATION

PEHP Waist Aweigh

801-366-7300 | 855-366-7300

» E-mail: waistaweigh@pehp.org

» Web: www.pehp.org

If you are unable to meet the medical standards to qualify for our weight management program and reach ongoing requirements, because it is unreasonably difficult due to a medical condition, upon written notification, PEHP will accept physician recommendation and/or modification to provide you with a reasonable alternative standard to participate. Members who claim PEHP Waist Aweigh rebates* are ineligible for the PEHP Healthy Utah BMI Improvement rebate*. The total amount of rewards cannot be more than 30% of the cost of employee-only coverage under the plan.

Life Assistance Counseling

PEHP pays for members to use Blomquist Hale Consulting for distressing life problems such as: marital struggles, financial difficulties, drug and alcohol issues, stress, anxiety, depression, despair, death in family, issues with children, and more. Blomquist Hale Life Assistance Counseling is a confidential counseling and wellness service provided to members and covered at 100% by PEHP.

FOR MORE INFORMATION

Blomquist Hale, 800-926-9619

» Web: www.blomquisthale.com

**FICA tax may be withheld from all wellness rebates. This will slightly lower any amount you receive. PEHP will mail additional tax information to you after you receive your rebate. Consult your tax advisor if you have any questions*

PEHP Dental Care

Introduction

PEHP wants to keep you healthy and smiling brightly. We offer dental plans that provide coverage for a full range of dental care.

When you use in-network providers, you pay a specified co-pay and PEHP pays the balance. When you use out-of-network providers, PEHP pays a specified portion of the In-Network Rate (In-Network Rate), and you are responsible for the balance.

There is no deductible for Diagnostic or Preventive services.

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

There is a Waiting Period of six months from the effective date of coverage for Orthodontic, Implant, and Prosthodontic benefits.

Members returning from military service will have the six-month waiting period for orthodontics waived if they reinstate their dental coverage within 90 days of their military discharge date.

Missing Tooth Exclusion

Services to replace teeth that are missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP.

However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge or denture was in place at the time the coverage became effective.

Limitations and Exclusions

Written preauthorization may be required for prosthodontic services. Preauthorization is not required for orthodontics.

Refer to the Dental Care Master Policy for complete benefit limitations, exclusions, and specific plan guidelines.

Master Policy

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

Preferred Dental Care

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines.

Plan year deductible is \$25 per member, up to a \$75 maximum per family. Does not apply to preventive or diagnostic services.	
Maximum Yearly Benefit per Member is \$1,500.	
DIAGNOSTIC	
Periodic Oral Examinations <i>Non-Specialist</i>	No charge
X-rays	20% of In-Network Rate
PREVENTIVE	
Cleanings and Fluoride Solutions	20% of In-Network Rate
Sealants <i>Permanent molars only through age 17</i>	20% of In-Network Rate
RESTORATIVE	
Amalgam Restoration	20% of In-Network Rate after deductible
Composite Restoration	20% of In-Network Rate after deductible
ENDODONICS	
Pulpotomy	20% of In-Network Rate after deductible
Root Canal	20% of In-Network Rate after deductible
PERIODONTICS	
20% of In-Network Rate after deductible	
ORAL SURGERY	
Extractions	20% of In-Network Rate after deductible
ANESTHESIA	
General Anesthesia <i>in conjunction with oral surgery or impacted teeth only</i>	20% of In-Network Rate after deductible
PROSTHODONTIC BENEFITS	
<i>Preauthorization may be required</i>	
Crowns	50% of In-Network Rate after deductible
Bridges	50% of In-Network Rate after deductible
Dentures (partial)	50% of In-Network Rate after deductible
Dentures (full)	50% of In-Network Rate after deductible
IMPLANTS	
All related services	50% of In-Network Rate after deductible
ORTHODONTIC BENEFITS	
Maximum Lifetime Benefit per member is \$1,500.	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum after deductible

Traditional Dental Care

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines.

Maximum Yearly Benefit per member is \$1,500.	
DIAGNOSTIC	
Periodic Oral Examinations	No charge
X-rays	No charge
PREVENTIVE	
Cleanings and Fluoride Solutions	No charge
Sealants <i>Permanent molars only through age 17</i>	No charge
RESTORATIVE	
Amalgam Restoration	20% of In-Network Rate
Composite Restoration	20% of In-Network Rate
ENDODONICS	
Pulpotomy	20% of In-Network Rate
Root Canal	20% of In-Network Rate
PERIODONTICS	
20% of In-Network Rate	
ORAL SURGERY	
Extractions	20% of In-Network Rate
ANESTHESIA	
General Anesthesia <i>in conjunction with oral surgery or impacted teeth only</i>	20% of In-Network Rate
PROSTHODONTIC BENEFITS	
<i>Preauthorization may be required</i>	
Crowns	50% of In-Network Rate
Bridges	50% of In-Network Rate
Dentures (partial)	50% of In-Network Rate
Dentures (full)	50% of In-Network Rate
IMPLANTS	
All related services	50% of In-Network Rate
ORTHODONTIC BENEFITS	
Maximum Lifetime Benefit per member is \$1,500.	
Eligible Appliances and Procedures	50% of eligible fees to plan maximum

Visit one of the State dental clinics to receive a 10% discount off of the Allowed Amount (see page 6 for more information).

Regence ExpressionsSM Dental Plan

\$0 Deductible
\$1,500 Max July 1, 2015

STATE OF UTAH
Effective Date: July 1, 2015



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Summary

Deductible per contract year	\$0 Per Member Deductible \$0 Family Deductible
Maximum benefit per contract year	\$1,500 Per Member

Understanding Your Benefits

- Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered services up to any maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).
- We do not reimburse Dentists for charges above the allowed amount. A **Participating Dentist** will not charge you for any balances for covered services beyond your coinsurance amount. **Nonparticipating Dentists**, however, may bill you for any balances over our payment level in addition to any coinsurance amount. You can find a list of providers at our Website or by calling Customer Service.

Covered Dental Services (Per Member)

Member Responsibility

Covered Dental Services (Per Member)	Member Responsibility
Preventive Dental Services <ul style="list-style-type: none"> Bitewing x-rays: 2 per contract year Complete intra-oral mouth x-rays: Once in a 3-year period Cleanings: 2 per contract year (in lieu of periodontal maintenance) Oral examinations: 2 per contract year Panoramic mouth x-rays: Once in a 3-year period Sealants (bicuspid and molars only): Under 15 years of age Space Maintainers: Under 13 years of age Topical fluoride application: Under 26 years of age, 2 treatments per contract year 	0%
Basic Dental Services <ul style="list-style-type: none"> Repair of Bridges, Crowns, Dentures: Coverage for adjustments and repair allowed one year of after placement Endodontic services including root canal treatment, pulpotomy and apicoectomy Emergency treatment for pain relief Fillings consisting of composite and amalgam restorations General dental anesthesia or intravenous sedation (subject to necessity) Uncomplicated and complex oral surgery procedures Periodontal maintenance: 2 per plan year (in lieu of preventive cleanings) Periodontal debridement: Once in a 3-year period Periodontal scaling and root planing: 2 per contract year Vestibuloplasty 	20%
Major Dental Services <ul style="list-style-type: none"> Bridges: Except no benefits are provided for replacement made fewer than 5-years after placement Crowns: Except no benefits are provided for replacement made fewer than 5-years after placement Dentures (full and partial): Except no benefits are provided for replacement made fewer than 5-years after placement Implants (endosteal) 	50%
Orthodontia Services <ul style="list-style-type: none"> Orthodontic treatment: No age limit \$1,500 per member lifetime maximum benefit 	50%

Dental Exclusions

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law.

Aesthetic Dental Procedures: Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents: Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens

Condition Caused By Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.

Condition Incurred In or Aggravated During Performances In the Uniformed Services: The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as result of injury or illness.

Desensitizing: Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Duplicate X-Rays

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract except as may be provided under the other continuation options of the contract.

Facility Charges: Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a dentist might bill.

Fractures of the Mandible: Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program.

Home Visits

Implants: Services and supplies provided in connection with implants, whether or not the implant itself is covered.

Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions).

Medications and Supplies including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Insurance Liability

Nitrous Oxide

Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.

Occlusal Treatment: Services and supplies provided in connection with dental occlusion, including occlusal analysis, adjustments and occlusal guards.

Oral Hygiene Instructions

Oral Surgery treating any fractured jaw and orthognathic surgery. By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Personal Comfort Items: Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.

Photographic Images

Pin Retention in Addition to Restoration

Precision Attachments

Prosthesis including maxillofacial prosthetic procedures and modification of removable prosthesis following implant surgery.

Provisional Splinting

Replacements: Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Dental Exclusions

Riot, Rebellion and Illegal Acts: Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs

Separate Charges: Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure) including any supplies, local anesthesia and sterilization.

Services and Supplies Provided by a Member of Your Family

Services Performed in a Laboratory

Surgical Procedures: Services and supplies provided in connection with the following surgical procedures: exfoliative cytology sample collection or brush biopsy; incision and drainage of abscess extraoral soft tissue, complicated or non-complicated; radical resection of maxilla or mandible; removal of nonodontogenic cyst, tumor or lesion; surgical stent and surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Dysfunction Treatment

Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

Tooth Transplantation: Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Travel and Transportation Expenses

Work-Related Conditions: Expenses for services and supplies incurred as a result of any work related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description of your dental plan benefits, limitations and exclusions under your dental plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, www.Regence.com. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply and a definition of dentally appropriate.

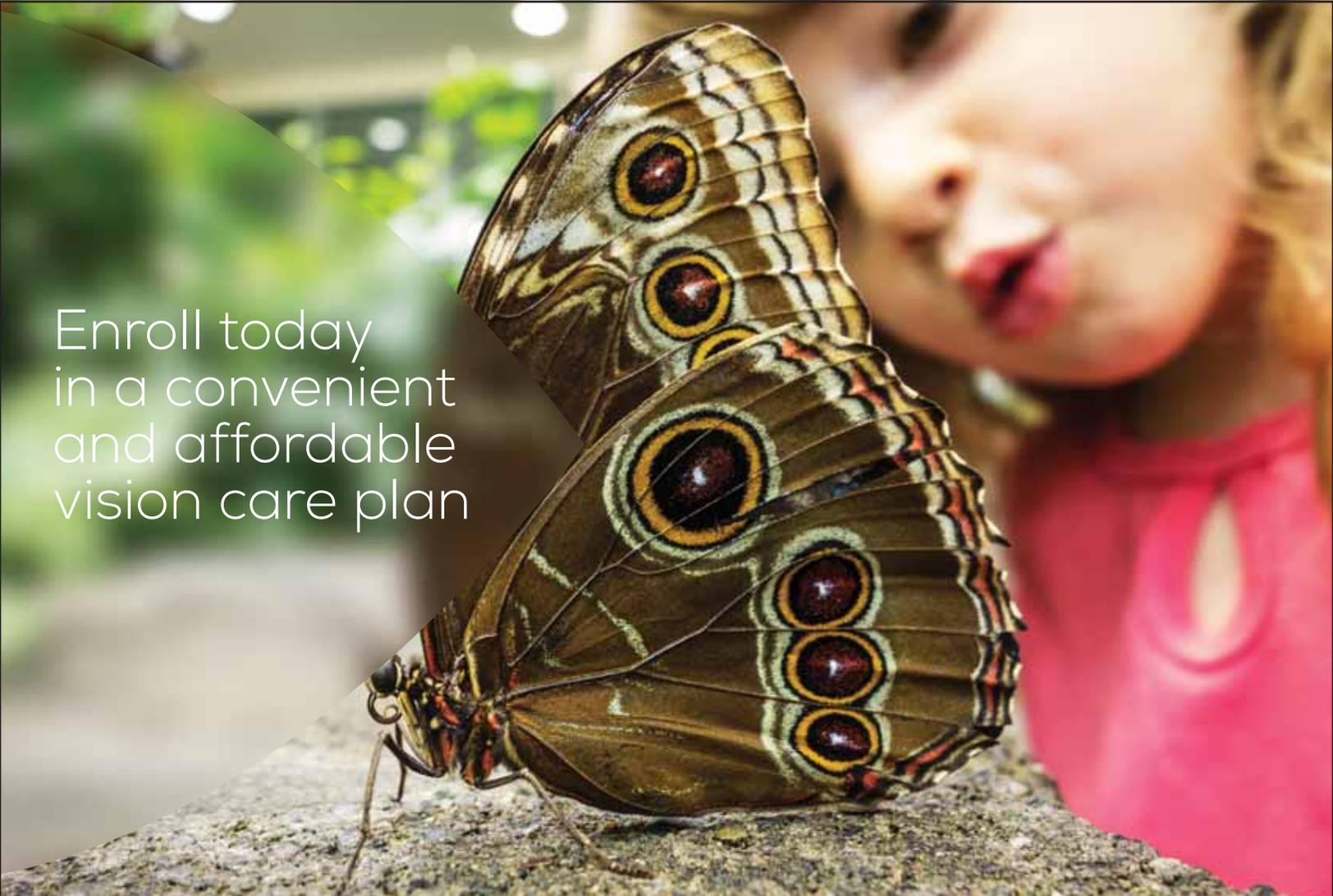


Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Contact Customer Service at 1 (888) 367-2119

www.regence.com



Enroll today
in a convenient
and affordable
vision care plan

You get vision wellness for you and your family

Regular eye exams measure your eyesight and they also can detect other serious illnesses such as diabetes, heart disease and high blood pressure.

You get great savings of approximately 40% with only a \$10 eye exam copay

And, those who receive an annual eye exam with their medical plan also have a vision hardware choice. Save on eye exams, eyeglasses and contacts with vision coverage through your EyeMed plan.

You get convenience and choice

Use your benefit at thousands of private practice and leading optical retail locations close to where you live, work and shop.

Enroll today! For more information, see plan details on next page.



The biggest network and the most choice. Because more is more.

You're on the Insight Network

For a complete list of providers near you, use our Provider Locator on eyemed.com or call 1.866.804.0982. For LASIK providers, call 1.877.5LASER6 or visit eyemedlasik.com.

Vision Plan Options	EyeMed Full (H)	EyeMed Eyewear Only (F)
Network	Insight Network	Insight Network
Benefit Frequencies (exam, lenses, frame)	12, 12, 12 (months)	N/A, 12, 12 (months)
Co-pays	\$10 exam, \$10 lenses	\$10 lenses
Exam	Covered in full	N/A
Exam Options		
Standard Fit follow-up	Upt to \$55	N/A
Premium Fit follow-up	10% of Retail	
Retinal Imaging	Up to \$39 covered	N/A
Frame	Covered up to \$100, 20% off balance	Covered up to \$130, 20% off balance
Lenses		
Single Vision, Bifocal, Trifocal (plastic)	Covered in full	Covered in full
Lenticular	Covered in full	Covered in full
Standard Progressives	\$75	\$75
Premium Progressives	\$95-\$120	\$95-\$120
Lens Options		
UV Protection	\$15	\$15
Tint (solid and gradient)	\$15	\$15
Standard Plastic Scratch Coating	\$15	\$15
Standard Polycarbonate - Adults	\$40	\$40
Standard Polycarbonate - Children	\$40	\$40
Standard Anti-Reflective Coating	\$45	\$45
Premium Anti-Reflective Coating	\$57 - \$68	\$57 - \$68
Photochromic/Transitions Plastic	\$75	\$75
Other add-ons	20% off retail	20% off retail
Contact Lenses (in lieu of lenses)		
Conventional	\$120 allowance, 15% off balance	\$130 allowance, 15% off balance
Disposable	\$120 allowance	\$130 allowance
Discounts		
LASIK and PRK Vision Correction	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price
Additional Complete Pairs	40%	40%
Additional Conventional Contact Lenses	15%	15%

Benefits may not be combined with any discount, promotional offering or other group benefit plans. Member will receive 20% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses. Benefit allowances provide no remaining balance for future use within same benefit frequency. There are certain brand-name Vision Materials in which the manufacturer imposes a no-discount practice. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Limitations and Exclusions apply.

Value-Added Features:

In addition to the health benefits your EyeMed program offers, members also enjoy additional, value-added features including:

- **Additional Eyewear** - Save up to 40% off additional complete pairs of glasses after the initial benefit has been used. This money-saving program is available at any participating provider.
- **Eye Care Supplies** - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchases at network providers (not valid on doctor's services or contact lenses).
- **Laser Vision Correction** - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.



LOOK GOOD. SEE WELL.

**It's not about how much you can see,
it's about how well you can see.**

Every eye is different and we don't believe in cookie-cutter procedures. Custom LASIK provides wavefront scanning and custom mapping to give you a safer, more precise treatment that is as unique as your fingerprint.

▶ **SAVE \$1,500 On Custom LASIK Surgery.**

PEHP Opticare members save up to \$750 per eye on custom LASIK vision correction surgery.

LASIK surgery discount available at Standard Optical locations ONLY. All prescriptions welcome. Some restrictions apply. See store for details. Price may vary based on prescription. Financing available.





Opticare Plan: 10-120C/120C

PLAN OPTIONS:

10-120C Full Benefits-(Eye exam and hardware benefit)*

OR

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

PEHP State of Utah	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)			
Contact benefits is in lieu Of lens and frame benefit.	\$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

*Co-pays for Progressive lenses may vary. This is a summary of plan benefits. The actual Policy will detail all plan limitations and exclusions.

Discounts

Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

** 50% discount at Standard Optical locations only. All other Network discounts vary from 20% - 35%.

***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** – Allowances are reimbursed at 75% when discounts are applied to merchandise. Promotional items or Online purchases not covered.

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