PEHP

JORDAN SCHOOL DISTRICT
ADVANTAGE AND SUMMIT MEDICAL PLANS

Effective September 2022

Advantage and Summit Medical Benefits

This Benefits Summary should be used in conjunction with the Jordan School District Master Policy. It contains information that only applies to PEHP Subscribers who are employed by Jordan School District 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 Jordan School District 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.

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1/19/23

Table of Contents

MEDICAL

Advantage & Summit. 5

- Advantage/Summit Traditional Medical Benefits Summary 7
- Advantage/Summit Value Medical Benefits Summary . . 12
- Advantage/Summit STAR Medical Benefits Summary . . 17
- Advantage/Summit Medical Master Policy 22

NOTICE OF PRIVACY PRACTICES 66

CREDITABLE COVERAGE DISCLOSURE NOTICE 69

PRESCRIPTION MEDICATION PROGRAM 72

FLEXIBLE SPENDING PLAN 74

Contact List

PEHP

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

Preauthorization of inpatient facility 801-366-7755
Toll-Free 800-753-7754

MENTAL HEALTH

Blomquist Hale Consulting Group (BHCG) 801-262-9619
Toll-Free 800-926-9619

PEHP HEALTHY UTAH 801-366-7300
Toll-Free 855-366-7300
Website . . . . . www.pehp.org

PEHP HEALTH COACHING 801-366-7300
Toll-Free 855-366-7300

PEHP WEECARE 801-366-7400
Toll-Free 855-366-7400
Website . . . . . www.pehp.org/wellness/weecare

PEHP PLUS . . . . . www.pehp.org/plus

www.pehp.org

PEHP's website—*www.pehp.org*—provides excellent information to members. In addition, members may verify all personal enrollment information, view beneficiaries, and review up to two years of history for medical claims. Members can print copies of Explanations of Benefits for tax purposes, 125 Cafeteria Plan reimbursements, and Co-pays.

The website contains the most current directory of In-Network Providers, specific benefit summaries for each PEHP group, a section of frequently asked questions, and information on personal health concerns. The website also includes useful links to other websites, such as Express Scripts, WeeCare, and PEHP's value-added program PEHPplus. Nearly all of PEHP's forms are also available on the website.

Provider Networks

PEHP offers Jordan School District members a choice of two different provider networks, Advantage and Summit.

The Advantage Provider Network offers the choice of the Intermountain Health Care provider network. This includes all of the Intermountain Health Care Hospitals statewide.

The Summit Provider Network offers the choice of the Mountain Star, Iasis and University of Utah hospital networks, in addition to over 7,500 providers statewide.

Additional Benefit Programs

PEHP Healthy Utah

PEHP Healthy Utah is a free program aimed at enhancing the well-being of members by increasing awareness of health risks and the importance of making healthy lifestyle choices, and providing support in making health-related lifestyle changes. PEHP Healthy Utah offers a variety of programs, services, and resources to help members get and stay well.

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 or 855-366-7300
» **Email: healthyutah@pehp.org**
» **Web: www.pehp.org**

PEHP Healthy Utah rebates may be taxable. Please consult with your tax advisor for tax advice concerning your benefits.

PEHP Health Coaching

PEHP Health Coaching is for those with a Body Mass Index (BMI) of 30 or higher, this lifestyle behavior change program provides education, support, and rebates to help you succeed in meeting your health goals. By developing an action plan and working with a health coach, participants' focus goes beyond weight loss to greater benefits of lasting health and well-being.

For more information about PEHP Health Coaching and to apply, go to www.pehp.org.

FOR MORE INFORMATION
PEHP Health Coaching
801-366-7300 | 855-366-7300
» **E-mail: healthcoaching@pehp.org**
» **Web: www.pehp.org**

PEHP WeeCare

PEHP WeeCare is our pregnancy case management service. It's a prenatal risk reduction program that offers education and consultation to expectant mothers.

Participate in PEHP WeeCare and you may qualify to get free pre-natal vitamins, free books, and cash incentives.

While PEHP WeeCare is not intended to take the place of your doctor, it's another resource for answers to questions during pregnancy.

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/wellness/weecare**

PEHPplus

The money-saving program PEHPplus helps promote good health and saves you money It provides savings of up to 60 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. Learn more at www.pehp.org/plus.

Hospital Comparison

PEHP Summit

PEHP Summit consists of predominantly Steward Health, MountainStar, and University of Utah Health Care providers and facilities.

PARTICIPATING HOSPITALS

Beaver County
- Beaver Valley Hospital
- Milford Valley Memorial Hospital

Box Elder County
- Bear River Valley Hospital
- Brigham City Community Hospital

Cache County
- Cache Valley Hospital
- 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
- Jordan Valley Hospital - West

Salt Lake County (cont.)
- Lone Peak Hospital
- Primary Children's Medical Center
- 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 Regional 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

PEHP Advantage

PEHP Advantage consists of predominantly Intermountain Healthcare (IHC) providers and facilities.

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
- Intermountain Layton Hospital

Duchesne County
- Uintah Basin Medical Center

Garfield County
- Garfield Memorial Hospital

Grand County
- Moab Regional Hospital

Iron County
- Cedar City Hospital

Juab County
- Central Valley Medical Center

Kane County
- Kane County Hospital

Millard County
- Delta Community Hospital
- Fillmore Community Hospital

Salt Lake County
- Alta View Hospital
- Intermountain Medical Center
- The Orthopedic Specialty Hospital (TOSH)

Salt Lake County (cont.)
- 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 Regional Medical Center

Utah County
- American Fork Hospital
- Orem Community Hospital
- Spanish Fork Hospital – coming 4/21
- Utah Valley Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- Dixie Regional Medical Center

Weber County
- McKay-Dee Hospital

Find Participating Providers

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

Jordan School District

Advantage & Summit Medical Benefits Summary

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Advantage & Summit Benefits Overview

Introduction

This Benefits Summary amends the PEHP Master Policy as set forth herein. The Benefits Summary is a description of Eligible Benefits and/or Co-pays when all eligibility requirements are met. Some benefits are subject to reduced percentages and/or dollar limitations. For a complete description, see the Plan guidelines, Limitations and Exclusions sections of the Master Policy.

All benefits are subject to the In-Network Rate as determined by Public Employees Health Program (PEHP) and the Maximum yearly or Lifetime limits. **Refer to the Master Policy for specific criteria for benefits, as well as information on Limitations and Exclusions.**

PREAUTHORIZATION

To be eligible, some inpatient hospitalization requires Preauthorization and some other services require Preauthorization by PEHP and may be subject to a reduction or denial of benefits if not complete. For a complete list of services that require Preauthorization, please see Section VII of the Master Policy. Mental Health and Substance Abuse admissions not Preauthorized are denied.

Preauthorized benefits are subject to all plan provisions and eligibility at time of service, and plan changes with new plan year provisions.

DENTAL ACCIDENT BENEFIT

Dental services by a physician or dentist for the treatment of a dental injury to sound natural teeth (including any necessary dental x-rays) are covered. The injury must occur while covered under this Plan. Treatment must begin within 72 hours of the injury and be completed within one year from the date of injury. Requires Preauthorization.

Dental injury means an injury to sound natural teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Sound natural teeth means teeth that are whole or properly restored; are without impairment or periodontal disease; and are not in need of the treatment provided for reasons other than dental injury.

Orthodontia services are not included in the Dental Accident Benefit.

ENROLLMENT PERIOD

A Subscriber has 30 days from his/her hire date to enroll for Coverage, or within 60 days in cases of divorce or legal separation. If the Subscriber fails to enroll during this time period he/she must wait until the next annual enrollment period to enroll.

Spouse and Dependent children may be enrolled within 30 days from the date of birth, or placement in your home, or from the date of marriage, or within 60 days from the date the dependent satisfies or ceases to satisfy eligibility requirements. If not enrolled during this time period, Dependents must wait until the next enrollment period to be eligible for Coverage in the next contract year.

For more detailed information regarding enrollment and eligibility issues, please refer to Section I of this Master Policy.

Advantage & Summit Traditional Medical Benefits Summary

Refer to the Advantage & Summit Provider Plans Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions

DEDUCTIBLES, OUT-OF-POCKET LIMITS	
Plan Year Medical Deductible	**In Network:** $500 per individual, $1,500 per family **Out of Network:** $1,000 per individual, $3,000 per family
Plan Year Medical Out-of-Pocket Maximum Limits	**In Network:** $5,000 per individual, $10,000 per family **Out of Network:** $10,000 per individual, $20,000 per family

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider*
Adoption	100% up to $2,500 after deductible. See Limitations	100% up to $2,500 after deductible. See Limitations
Allergy Injections	80% of In-Network Rate	60% of In-Network Rate after Deductible
Allergy Serum	100% of In-Network Rate after $55 Co-pay per plan year	60% of In-Network Rate after Deductible
Ambulance, ground or air	80% of In-Network Rate	80% of In-Network Rate
Ambulatory Surgical Facility	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Anesthesia	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Assistant Surgeon	80% of In-Network Rate after Deductible (In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details)	60% of In-Network Rate after Deductible (In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details)
Cardiac Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	100% of In-Network Rate after applicable office Co-pay per visit	60% of In-Network Rate after Deductible
Chemotherapy, Outpatient, Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chiropractic Therapy Up to 20 visits per plan year	100% of In-Network Rate after $40 Co-pay per visit	Not covered
Missing Teeth for Dental Accident or Certain Medical Conditions Requires preauthorization. Dental benefits may apply	80% of In-Network Rate after Deductible. Requires Preauthorization	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. Requires Preauthorization
Diagnostic Radiology/Testing		
Inpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	100% of In-Network Rate for each service allowing up to $350 80% of In-Network Rate after Deductible for each service allowing more than $350	60% of In-Network Rate after Deductible
Diagnostic Laboratory *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	100% of In-Network Rate for each service allowing up to $350 80% of In-Network Rate after Deductible for each service allowing more than $350	60% of In-Network Rate after Deductible
Dialysis, Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible. Requires Preauthorization
Emergency Room *Facility*	100% of In-Network Rate after Deductible and $150 Co-pay per visit	100% of In-Network Rate after Deductible and $150 Co-pay per visit plus any balance billing above In-Network Rate
Physician	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider*
Functional Reconstructive Surgery, Physician	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Hearing Aids up to $1,500 every 5 years	80% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations	60% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations
Home Healthcare	All services require Preauthorization	All services require Preauthorization
Skilled Nursing up to 60 visits per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
IV Therapy (antibiotics)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chemotherapy, Dialysis	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physical, Occupational, Speech Therapy Maximum limits apply	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Licensed Clinical Social Worker Maximum limits apply	100% of In-Network Rate after $40 Co-pay per visit	50% of In-Network Rate after Deductible
Total Parenteral Nutrition (TPN)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Enteral (Tube) Feeding	80% of In-Network Rate after Deductible for supplies	60% of In-Network Rate after Deductible for supplies
Enteral Formula	If approved by PEHP, must be obtained through the Pharmacy Card	If approved by PEHP, must be obtained through the Pharmacy Card
Hospice Services	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Hospital *Inpatient* All out-of-network facilities and some in-network facilities require Preauthorization. See Master Policy for details	80% of In-Network Rate after Deductible.	60% of In-Network Rate after Deductible.
Inpatient Ancillary	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician Visits	80% of In-Network Rate	60% of In-Network Rate after Deductible
Hyperbaric Oxygen Treatment	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Injections	80% of In-Network Rate	60% of In-Network Rate after Deductible
Jaw Surgery (Osteotomy/TMJ Surgery)	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Medical Equipment/Supplies (DME) See Master Policy for Limitations	Certain DME requires Preauthorization	Certain DME requires Preauthorization
Medical Supplies – Office	80% of In-Network Rate	60% of In-Network Rate after Deductible
General	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Disorder Equipment: One CPAP/BiPAP per 5 years. Supplies: Limited to $325 in a plan year. One oral sleep appliance per 5 years.	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Wheelchairs *(including parts and replacements)* One power wheelchair in a 5-year period. See Limitations	80% of In-Network Rate after Deductible	60% 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.

Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider*
Knee Braces One custom and one off-the-shelf per knee in a 3-year period. See Limitations	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Mental Healthcare	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Outpatient Therapy—Mental Health/Substance Abuse Up to 25 combined visits per plan year	100% of In-Network Rate after $40 Co-pay per visit	50% of In-Network Rate after Deductible
Neuro-psychiatric Testing	100% of In-Network Rate for each service allowing up to $350 80% of In-Network Rate after Deductible for each service allowing more than $350	60% of In-Network Rate after Deductible
Occupational Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits per plan year	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Office Visits		
Primary Care	100% of In-Network Rate after $30 Co-pay per visit	60% of In-Network Rate after Deductible
Specialist	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
PEHP e-Care	$10 Co-pay per visit	Not applicable
PEHP Value Clinics	$10 Co-pay per visit	Not applicable
Urgent Care	100% of In-Network Rate after $50 Co-pay per visit	60% of In-Network Rate after Deductible
Orthotics $200 maximum per plan year	80% of In-Network Rate	60% of In-Network Rate after Deductible
Physical Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits and up to 10 additional physical therapy visits per plan year	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Prescription Medications		
Retail up to 30-day supply	Generic—$15 Co-pay Preferred—Member pays 35% Non-Preferred—Member pays 50% Specialty— Member pays 50%	Member pays 50%
Mail Order up to 90-day supply	Generic—$30 Co-pay Preferred—Member pays 35% Non-Preferred—Member pays 50% Specialty — Member pays 50%	Not covered

*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.

Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider*
Diabetic Supplies	Pharmacy benefits apply	Pharmacy benefits apply
Food Supplements	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply
Foreign Country Claims	Pharmacy benefits apply	Pharmacy benefits apply
Specialty Medications, Office	50% of In-Network Rate	50% of In-Network Rate after Deductible
Specialty Medications, Outpatient	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Prosthetics Limited to one per site in a 5-year period. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Psychiatric Testing	100% of In-Network Rate for each service allowing up to $350 80% of In-Network Rate after Deductible for each service allowing more than $350	60% of In-Network Rate after Deductible
Pulmonary Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	100% of In-Network Rate after applicable office Co-pay per visit	60% of In-Network Rate after Deductible
Radiation Therapy	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Rehabilitation *Inpatient Room and Board* Up to 30 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Inpatient Ancillary	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Second Surgical Opinion	80% of In-Network Rate	60% of In-Network Rate after Deductible
Skilled Nursing Facility (SNF), non-custodial Up to 60 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Studies Limited to $2,000 in a 3-year period. Requires Preauthorization when services performed in a facility or when attended by a technician	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Speech Therapy		
Outpatient/Office Limited to 60 visits per lifetime (must meet criteria to be Eligible)	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Substance Abuse Treatment	Paid from Mental Health benefits. Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	Paid from Mental Health benefits. Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider*
Outpatient Therapy—Substance Abuse/Mental Health Up to 25 combined visits per plan year	100% of In-Network Rate after $40 Co-pay per visit	50% of In-Network Rate after Deductible
Surgery, Physician *Inpatient or Outpatient Facility*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician's Office	80% of In-Network Rate	60% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction (TMJ, TMD), non-surgical Up to a $500 Lifetime Maximum	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Transplants	Payable with applicable Co-pays per service rendered Requires Preauthorization	Payable with applicable Co-pays per service rendered Requires Preauthorization
Urgent Care Facility	100% of In-Network Rate after $50 Co-pay per visit	60% of In-Network Rate after Deductible
WellCare Program, annual routine care		
Routine Vision Exams 1 visit per plan year	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Routine Hearing Exams 1 visit per plan year	100% of In-Network Rate after $40 Co-pay per visit	60% of In-Network Rate after Deductible
Diabetes Education (Must be for the diagnosis of diabetes)	100% of In-Network Rate	60% of In-Network Rate after Deductible
Affordable Care Act Preventive Services See Master Policy for complete list		
Routine Physical Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Gynecological Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Mammogram 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Well-Baby Exams	100% of In-Network Rate	Not covered
Covered Immunizations (See Master Policy for complete list)	100% of In-Network Rate	Not covered
Osteoporosis Screening (age 60 and over) 1 per plan year	100% of In-Network Rate	Not covered
Routine Sigmoidoscopy (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered
Colonoscopy Screening (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered

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Advantage & Summit Value Plan Medical Benefits Summary

Refer to the Advantage & Summit Provider Plans Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

DEDUCTIBLES, OUT-OF-POCKET LIMITS	
Plan Year Deductible	**Medical, In Network:** $1,250 per individual, $3,750 per family **Medical, Out of Network:** $2,500 per individual, $7,500 per family **Prescription Medications:** $250 per individual
Plan Year Medical Out-of-Pocket Maximum Limits	**In Network:** $5,000 per individual, $10,000 per family **Out of Network:** $10,000 per individual, $20,000 per family

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Adoption	100% up to $2,500 after deductible. See Limitations	100% up to $2,500 after deductible. See Limitations
Allergy Injections	80% of In-Network Rate	60% of In-Network Rate after Deductible
Allergy Serum	80% of In-Network Rate	60% of In-Network Rate after Deductible
Ambulance, ground or air	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible
Ambulatory Surgical Facility	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Anesthesia	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Assistant Surgeon	80% of In-Network Rate after Deductible (In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details)	60% of In-Network Rate after Deductible (In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details)
Cardiac Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	100% of In-Network Rate after applicable office Co-pay per visit	60% of In-Network Rate after Deductible
Chemotherapy, Outpatient, Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chiropractic Therapy Up to 20 visits per plan year	100% of In-Network Rate after $35 Co-pay per visit	Not covered
Missing Teeth for Dental Accident or Certain Medical Conditions Three or more missing teeth at a time, and per lifetime. Requires preauthorization. Dental benefits may apply	80% of In-Network Rate after Deductible. Requires Preauthorization	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. Requires Preauthorization
Diagnostic Radiology/Testing *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	80% of In-Network Rate for each test allowing up to $350 80% of In-Network Rate after Deductible for each test allowing more than $350	60% of In-Network Rate after Deductible
Diagnostic Laboratory *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	80% of In-Network Rate for each test allowing up to $350 80% of In-Network Rate after Deductible for each test allowing more than $350	60% of In-Network Rate after Deductible
Dialysis, Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible. Requires Preauthorization
Emergency Room *Facility*	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate
Physician	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Functional Reconstructive Surgery, Physician	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Hearing Aids up to $1,500 every 5 years	80% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations	60% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations
Home Healthcare	All services require Preauthorization	All services require Preauthorization
Skilled Nursing Up to 60 visits per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
IV Therapy (antibiotics)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chemotherapy, Dialysis	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physical, Occupational, Speech Therapy Maximum limits apply	100% of In-Network Rate after $35 Co-pay per visit.	60% of In-Network Rate after Deductible
Licensed Clinical Social Worker Maximum limits apply	100% of In-Network Rate after $35 Co-pay per visit.	50% of In-Network Rate after Deductible
Total Parenteral Nutrition (TPN)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Enteral (Tube) Feeding	80% of In-Network Rate after Deductible for supplies	60% of In-Network Rate after Deductible for supplies
Enteral Formula	If approved by PEHP, must be obtained through the Pharmacy Card	If approved by PEHP, must be obtained through the Pharmacy Card
Hospice Services	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Hospital *Inpatient* All out-of-network facilities and some in-network facilities require Preauthorization. See Master Policy for details	80% of In-Network Rate after Deductible.	60% of In-Network Rate after Deductible.
Inpatient Ancillary	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician Visits	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Hyperbaric Oxygen Treatment	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Injections	80% of In-Network Rate	60% of In-Network Rate after Deductible
Jaw Surgery (Osteotomy/TMJ Surgery)	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Medical Equipment/Supplies (DME) See Master Policy for Limitations	Certain DME requires Preauthorization	Certain DME requires Preauthorization
Medical Supplies – Office	80% of In-Network Rate	60% of In-Network Rate after Deductible
General	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Disorder Equipment: One CPAP/BiPAP per 5 years. Supplies: Limited to $325 in a plan year. One oral sleep appliance per 5 years.	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Wheelchairs Including parts and replacements one power wheelchair in a 5-year period. See Limitations	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Knee Braces One custom and one off-the-shelf per knee in a 3-year period. See Limitations	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Mental Healthcare	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible,
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Outpatient Therapy—Substance Abuse/Mental Health Up to 25 combined visits per plan year	100% of In-Network Rate after $35 Co-pay per visit	50% of In-Network Rate after Deductible
Neuro-psychiatric Testing	80% of In-Network Rate for each test allowing up to $350 80% of In-Network Rate after Deductible for each test allowing more than $350	60% of In-Network Rate after Deductible
Occupational Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits per plan year	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
Office Visits		
Primary Care	100% of In-Network Rate after $25 Co-pay per visit	60% of In-Network Rate after Deductible
Specialist Visit	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
PEHP e-Care	$10 Co-pay per visit	Not applicable
PEHP Value Clinics	$10 Co-pay per visit	Not applicable
Urgent Care	100% of In-Network Rate after $45 Co-pay per visit	60% of In-Network Rate after Deductible
Orthotics $200 maximum per plan year	80% of In-Network Rate	60% of In-Network Rate after Deductible
Physical Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits and up to 10 additional physical therapy visits per plan year	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
Prescription Medications $250 prescription medication deductible applies per individual per plan year for all medications		
Retail up to 30-day supply	Generic—$7 Co-pay Preferred—Member pays 20% Non-Preferred—Member pays 35% Specialty— Member pays 35%	Member pays 50%
Mail Order up to 90-day supply	Generic—$15 Co-pay Preferred—Member pays 20%; $150 maximum Co-pay Non-Preferred—Member pays 35%; $175 maximum Co-pay Specialty— Member pays 35%	Not covered

Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Diabetic Supplies	Pharmacy benefits apply	Pharmacy benefits apply
Food Supplements	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply
Foreign Country Claims	Pharmacy benefits apply	Pharmacy benefits apply
Specialty Medications, Office	65% of In-Network Rate (No Deductibles apply)	50% of In-Network Rate after medical Deductible
Specialty Medications, Outpatient	65% of In-Network Rate after medical Deductible	50% of In-Network Rate after medical Deductible
Prosthetics Limited to one per site in a 5-year period. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Psychiatric Testing	80% of In-Network Rate for each test allowing up to $350 80% of In-Network Rate after Deductible for each test allowing more than $350	60% of In-Network Rate after Deductible
Pulmonary Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	100% of In-Network Rate after applicable office Co-pay per visit	60% of In-Network Rate after Deductible
Radiation Therapy	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Rehabilitation, Inpatient Up to 30 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Second Surgical Opinion	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Skilled Nursing Facility (SNF), non-custodial Up to 60 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Studies Limited to $2,000 in a 3-year period. Requires Preauthorization when services performed in a facility or when attended by a technician	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Speech Therapy		
Outpatient/Office Limited to 60 visits per lifetime (must meet criteria to be Eligible)	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
Substance Abuse Treatment	Paid from Mental Health benefits Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	Paid from Mental Health benefits Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Outpatient Therapy—Substance Abuse/Mental Health Up to 25 combined visits per plan year	100% of In-Network Rate after $35 Co-pay per visit	50% of In-Network Rate after Deductible

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Surgery, Physician *Inpatient or Outpatient Facility*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician's Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Temporomandibular Joint Dysfunction (TMJ, TMD), non-surgical Up to a $500 Lifetime Maximum	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Transplants	Payable with applicable Co-pays per service rendered Requires Preauthorization (must meet criteria to be Eligible)	Payable with applicable Co-pays per service rendered Requires Preauthorization (must meet criteria to be Eligible)
Urgent Care Facility	100% of In-Network Rate after $45 Co-pay per visit	60% of In-Network Rate after Deductible
WellCare Program, annual routine care		
Routine Vision Exams 1 visit per plan year	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
Routine Hearing Exams 1 visit per plan year	100% of In-Network Rate after $35 Co-pay per visit	60% of In-Network Rate after Deductible
Diabetes Education (Must be for the diagnosis of diabetes)	100% of In-Network Rate	60% of In-Network Rate after Deductible
Affordable Care Act Preventive Services See Master Policy for complete list		
Routine Physical Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Gynecological Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Mammogram 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Well-Baby Exams	100% of In-Network Rate	Not covered
Covered Immunizations (See Master Policy for complete list)	100% of In-Network Rate	Not covered
Osteoporosis Screening (age 60 and over) 1 per plan year	100% of In-Network Rate	Not covered
Routine Sigmoidoscopy (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered
Colonoscopy Screening (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered

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Advantage & Summit STAR (QHDHP) Medical Benefits

Refer to the Advantage & Summit Provider Plans Master Policy for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

DEDUCTIBLES, OUT-OF-POCKET LIMITS	
Plan Year Deductible	**Medical, In Network:** $1,400 per single, $2,800 per family **Medical, Out of Network:** $2,800 per single, $5,600 per family
Plan Year Medical Out-of-Pocket Maximum Limits *Any one individual may not apply more than $5,000 toward the family In-Network Out-of-Pocket Maximum*	**In Network:** $5,000 per individual, $10,000 per family **Out of Network:** $10,000 per single, $20,000 per family

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Adoption	100% up to $2,500 after Deductible. See Limitations	100% up to $2,500 after deductible. See Limitations
Allergy Injections	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Allergy Serum	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Ambulance, ground or air	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible
Ambulatory Surgical Facility	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Anesthesia	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Assistant Surgeon	80% of In-Network Rate after Deductible In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details	60% of In-Network Rate after Deductible In-Network Rate is determined per Clinical Policy. Visit Clinical Policies at pehp.org or contact PEHP for details
Cardiac Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chemotherapy, Outpatient, Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chiropractic Therapy Up to 20 visits per plan year	80% of In-Network Rate after Deductible	Not covered
Missing Teeth for Dental Accident or Certain Medical Conditions Requires preauthorization. Dental benefits may apply	80% of In-Network Rate after Deductible. Requires Preauthorization	80% of In-Network Rate after Deductible plus any balance billing above In-Network Rate. Requires Preauthorization
Diagnostic Radiology/Testing *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Diagnostic Laboratory *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient/Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Dialysis, Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible. Requires Preauthorization
Emergency Room *Facility*	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
Physician	80% of In-Network Rate after Deductible	80% of In-Network Rate after Deductible, plus any balance billing above In-Network Rate
Functional Reconstructive Surgery, Physician	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Hearing Aids up to $1,500 every 5 years	80% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations	60% of In-Network Rate after Deductible. Requires Preauthorization. See Limitations
Home Healthcare	All services require Preauthorization	All services require Preauthorization
Skilled Nursing Up to 60 visits per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
IV Therapy (antibiotics)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Chemotherapy, Dialysis	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physical, Occupational, Speech Therapy Maximum limits apply	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Licensed Clinical Social Worker Maximum limits apply	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Total Parenteral Nutrition (TPN)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Enteral (Tube) Feeding	80% of In-Network Rate after Deductible for supplies	60% of In-Network Rate after Deductible for supplies
Enteral Formula	If approved by PEHP, must be obtained through the Pharmacy Card	If approved by PEHP, must be obtained through the Pharmacy Card
Hospice Services	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Hospital *Inpatient* All out-of-network facilities and some in-network facilities require Preauthorization. See Master Policy for details	80% of In-Network Rate after Deductible.	60% of In-Network Rate after Deductible.
Inpatient Ancillary	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician Visits	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Hyperbaric Oxygen Treatment	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Injections	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Jaw Surgery (Osteotomy/TMJ Surgery)	80% of In-Network Rate after Deductible. Requires Preauthorization	60% of In-Network Rate after Deductible. Requires Preauthorization
Medical Equipment/Supplies (DME) See Master Policy for Limitations	Certain DME requires Preauthorization	Certain DME requires Preauthorization
Medical Supplies – Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
General	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Disorder Equipment: One CPAP/BiPAP per 5 years. Supplies: Limited to $325 in a plan year. One oral sleep appliance per 5 years.	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Wheelchairs Including parts and replacements one power wheelchair in a 5-year period. See Limitations	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Knee Braces One custom and one off-the-shelf per knee in a 3-year period. See Limitations	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Mental Healthcare	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Outpatient Therapy—Substance Abuse/Mental Health Up to 25 combined visits per plan year	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Neuro-psychiatric Testing	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Occupational Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Office Visits		
Primary Care	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Specialist Visit	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
PEHP e-Care	$10 Co-pay per visit after Deductible	Not applicable
PEHP Value Clinics	80% of In-Network Rate after Deductible	Not applicable
Urgent Care	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Orthotics $200 maximum per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physical Therapy *Inpatient*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Outpatient Up to 20 combined occupational therapy and physical therapy visits and up to 10 additional physical therapy visits per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Prescription Medications		
Retail up to 30-day supply	Generic—80% of In-Network Rate after Deductible Preferred—80% of In-Network Rate after Deductible Non-Preferred—80% of In-Network Rate after Deductible Specialty— 80% of In-Network Rate after Deductible	Member pays 50% after Deductible
Mail Order up to 90-day supply	Generic—80% of In-Network Rate after Deductible Preferred—80% of In-Network Rate after Deductible Non-Preferred—80% of In-Network Rate after Deductible Specialty— 80% of In-Network Rate after Deductible	Not covered
Diabetic Supplies	Pharmacy benefits apply	Pharmacy benefits apply
Food Supplements	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply	Not covered, except as required for phenylketonuria (PKU) Requires Preauthorization. If approved, pharmacy benefits apply

*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.

Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Foreign Country Claims	Pharmacy benefits apply	Pharmacy benefits apply
Specialty Medications, Office	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialty Medications, Outpatient	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Foreign Country Claims	Pharmacy benefits apply	Pharmacy benefits apply
Specialty Medications, Office	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Specialty Medications, Outpatient	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Prosthetics Limited to one per site in a 5-year period. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Psychiatric Testing	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Pulmonary Rehabilitation, Phase 2 Up to 20 visits allowed per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Radiation Therapy	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Rehabilitation, Inpatient Up to 30 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Second Surgical Opinion	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Skilled Nursing Facility (SNF), non-custodial Up to 60 days per plan year. Requires Preauthorization	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Sleep Studies Limited to $2,000 in a 3-year period. Requires Preauthorization when services performed in a facility or when attended by a technician	80% of In-Network Rate after Deductible	60% of In-Network Rate after deductible
Speech Therapy		
Outpatient/Office Limited to 60 visits per lifetime (must meet criteria to be Eligible)	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Substance Abuse Treatment	Paid from Mental Health benefits. Requires Preauthorization through Blomquist Hale Consulting Group (BHCG) at 800-926-9619 or 801-262-9619	
Inpatient Hospital Residential treatment benefit; up to 60 day limit applies, no out-of-network coverage	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Intensive Outpatient Up to 32 days per plan year, once in five years	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Inpatient Physician Visits	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Outpatient Therapy—Substance Abuse/Mental Health Up to 25 combined visits per plan year	80% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Surgery, Physician *Inpatient or Outpatient Facility*	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Physician's Office	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible

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Coverage Levels (continued)

Description	Benefit When Using An In-Network Provider	Benefit When Using An Out-of-Network Provider *
Temporomandibular Joint Dysfunction (TMJ, TMD), non-surgical Up to a $500 Lifetime Maximum	50% of In-Network Rate after Deductible	50% of In-Network Rate after Deductible
Transplants	Payable with applicable Co-pays per service rendered Requires Preauthorization (must meet criteria to be Eligible)	Payable with applicable Co-pays per service rendered Requires Preauthorization (must meet criteria to be Eligible)
Urgent Care Facility	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
WellCare Program, annual routine care		
Routine Vision Exams 1 visit per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Routine Hearing Exams 1 visit per plan year	80% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Diabetes Education (Must be for the diagnosis of diabetes)	100% of In-Network Rate after Deductible	60% of In-Network Rate after Deductible
Affordable Care Act Preventive Services See Master Policy for complete list		
Routine Physical Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Gynecological Exam 1 visit per plan year	100% of In-Network Rate	Not covered
Mammogram 1 visit per plan year	100% of In-Network Rate	Not covered
Routine Well-Baby Exams	100% of In-Network Rate	Not covered
Covered Immunizations (See Master Policy for complete list)	100% of In-Network Rate	Not covered
Osteoporosis Screening (age 60 and over) 1 per plan year	100% of In-Network Rate	Not covered
Routine Sigmoidoscopy (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered
Colonoscopy Screening (age 45 and over) 1 per plan year	100% of In-Network Rate	Not covered

*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.

Medical Master Policy

RECITALS . . . 24

INTRODUCTION . . . 24

BILLING ACCURACY . . . 24

I. ENROLLMENT AND ELIGIBILITY . . . 24
1.1 Eligibility . . . 24
1.1.1 Enrollment Period . . . 24
1.1.2 Special Enrollment . . . 25
1.1.3 Loss of Other Coverage . . . 25
1.1.4 Transfer of Coverage . . . 25
1.2 Coverage While on Leave . . . 25
1.2.1 Military Leave . . . 25
1.2.2 Family and Medical Leave Act of 1993 . . . 26
1.3 Termination or Limitation of Coverage . . . 26
1.4 Extension of Benefits . . . 26
1.4.1 Continuation of Coverage Under COBRA . . . 26
1.4.2 Medicare Supplement . . . 29

II. ADMINISTRATION . . . 29
2.1 Master Policy . . . 29
2.2 Cooperation . . . 29
2.3 Authorization to Obtain/Retain/Share Information . . . 29
2.3.1 Request for Information . . . 29
2.4 Medical Review and Claim Verification . . . 29
2.5 Out-of-Network/Out of State Allowable Fees . . . 30
2.6 Out-of-country Coverage . . . 30
2.7 Liability for Services . . . 30
2.7.1 Excess Payment by the Plan . . . 30
2.8 Mandatory Care Coordination . . . 30
2.9 Confidentiality . . . 31
2.10 In-Network Providers . . . 31
2.11 Benefit Changes . . . 31
2.12 Rate Changes . . . 31
2.13 PEHP Employee Responses . . . 31
2.14 Notice of Women's Health and Cancer Rights Act . . . 31
2.15 Notice of Newborn's and Mother's Health Protection Act . . . 31
2.16 Notice of Exemption from HIPAA . . . 32
2.17 New Technology . . . 32

III. COORDINATION OF BENEFITS . . . 32
3.1 Coordination of Benefits (COB) with Other Carriers . . . 32
3.1.1 Order of Benefit Determination . . . 33
3.2 COB with other types of Plans . . . 33
3.3 COB with Medicare . . . 33
3.4 Auto Insurance/No-fault . . . 33
3.5 Correction of Payment in Error . . . 33

IV. SUBROGATION AND CONTRACTUAL REIMBURSEMENT . . . 33
4.1 Contractual Reimbursement . . . 33
4.2 Subrogation . . . 34
4.3 Acceptance of Benefits and Notification . . . 34
4.4 Recoupment of Benefit Payment . . . 34

V. CLAIMS SUBMISSION, INFORMATION AND APPEALS . . . 34
5.1 Claims Submission . . . 34
5.2 When A Member Needs Information . . . 35
5.2.1 Member's Responsibilities . . . 35
5.2.2 Request for Information by a Non-subscriber Parent . . . 35
5.3 Claims Appeals Process . . . 35

VI. ADDITIONAL BENEFITS PROGRAM . . . 36
6.1 National Access Program . . . 36

VII. PREAUTHAUTHORIZATION . . . 36
7.1 Preauthorization . . . 36
7.1.1 Written Preauthorization . . . 36
7.1.2 Verbal Preauthorization . . . 37
7.2 Preauthorization . . . 37

VIII. COVERED BENEFITS AND SERVICES . . . 37
8.1 Hospital Benefits . . . 37
8.1.1 Inpatient Hospitalization . . . 37
8.1.2 Outpatient Facility Benefits . . . 38
8.1.3 Hospital Preauthorization . . . 38
8.1.4 Emergency Room Services . . . 38
8.1.5 Urgent Care Facility . . . 38
8.1.6 Limitations relating to all Inpatient and Outpatient Services . . . 38
8.1.7 Exclusions from Coverage relating to all Inpatient and Outpatient Hospital/Facility and Emergency Room Services . . . 39
8.2 Surgical Benefits . . . 39
8.2.1 Second Opinion and Surgical Review . . . 39
8.2.2 Limitations relating to Surgery . . . 39
8.2.3 Exclusions from Coverage relating to Surgery . . . 40
8.3 Anesthesia Benefits . . . 41
8.3.1 Limitations relating to Anesthesia . . . 41
8.3.2 Exclusions from Coverage relating to Anesthesia . . . 41
8.4 Medical Visit Benefits . . . 41
8.4.1 Limitations relating to Medical Visits . . . 41
8.4.2 Exclusions from Coverage relating to Medical Visits . . . 42
8.5 Diagnostic Testing, Lab and X-ray Benefits . . . 43
8.5.1 Limitations relating to Diagnostic Testing, Lab and X-ray . . . 43
8.5.2 Exclusions from Coverage relating to Diagnostic Testing, Lab and X-ray . . . 44
8.6 Mental Health and Substance Abuse Benefits . . . 44
8.6.1 Facility and Hospital Services . . . 44
8.6.2 Inpatient Provider Visits . . . 44
8.6.3 Outpatient Provider Visits . . . 44
8.6.4 Limitations relating to Mental Health and Substance Abuse . . . 45
8.6.5 Exclusions from Coverage relating to Mental Health and Substance Abuse . . . 45
8.7 Ambulance Benefits . . . 45
8.7.1 Limitations relating to Ambulance Benefits . . . 45
8.7.2 Exclusions from Coverage relating to Ambulance Benefits . . . 45
8.8 Home Health and Hospice Care Benefits . . . 45
8.8.1 Limitations relating to Home Health and Hospice Care Benefits . . . 45
8.8.2 Exclusions from Coverage relating to Home Health and Hospice Care . . . 45
8.9 Adoption Benefits . . . 46
8.9.1 Exclusions from Coverage relating to Adoption Benefits . . . 46
8.10 Prescription Medication Benefits . . . 46
8.10.1 Out-of-area Prescriptions or Other Cash Purchases . . . 46
8.10.2 Covered Medications . . . 46
8.10.3 Limitations relating to Prescription Medication Benefits . 47
8.10.4 Exclusions from Coverage relating to Prescription Medication Benefits . . . 47
8.10.5 Preauthorization for Prescription and Specialty Medications . . . 48
8.10.6 Quantity Levels and Step Therapy . . . 49
8.10.7 Pharmacy Coordination of Benefits with Other Carriers . 49
8.10.8 Out-of-Area Prescriptions or Other Cash Purchases . . . 49
8.10.9 Specialty and Injectable Medications . . . 49
8.10.10 Prescriptions by Mail . . . 49
8.10.11 Generic Substitution Benefit . . . 50
8.10.12 Initial Reviews for Benefit Claims . . . 50
8.10.13 Appeals of Adverse Benefit Determinations Other Than Independent External Reviews . . . 50
8.10.14 Independent External Review Appeals of Adverse Benefit Determinations . . . 52
8.11 Durable Medical Equipment/Supply Benefit . . . 53
8.11.1 Limitations relating to Durable Medical Equipment/Supply Benefits . . . 53
8.11.2 Exclusions from Coverage relating to Durable Medical Equipment/Supply Benefit . . . 53
8.12 Preventive Services . . . 54
8.12.1 Covered Preventive Services for all Adults . . . 54
8.12.2 Covered Preventive Services Specifically for Women . . . 55
8.12.3 Covered Preventive Services for Children . . . 56
8.12.4 Pilot Program . . . 56

IX. CATASTROPHIC SICKNESS OR INJURY BENEFITS (OUT-OF-POCKET EXPENSES) . . . 57
9.1 Catastrophic Benefits . . . 57
9.1.1 Exclusions from Coverage relating to Catastrophic Sickness or Injury Benefits . . . 57

X. GENERAL EXCLUSIONS . . . 57
10.1 Specific Exclusions . . . 57
10.2 General Exclusions from Coverage . . . 57

XI. DEFINITIONS . . . 59

Recitals

This Master Policy is the contract between the Public Employees Health Program (PEHP) and its members and is intended to comply with the provisions of Title 49, Chapter 20 of the Utah Code Annotated, which creates the Public Employees Benefit and Insurance Program, also known as PEHP. The rights and obligations of the Members and PEHP are set forth in this Master Policy. If any term of this Master Policy is found to be in violation of Title 49, Chapter 20 of the Utah Code Annotated, that term shall be null and void and severable from the Master Policy and shall not render the Master Policy null and void as a whole. This contract is governed by and will be interpreted and enforced according to the laws of the state of Utah.

This contract, including all matters incorporated herein, including, but not limited to, benefit summaries and Enrollment forms, contains the entire agreement and it is binding upon Subscribers, Members and their heirs, successors, personal representatives and assignees in regard to their applicable Employer benefit plan. There are no promises, terms, conditions, or obligations other than those contained herein. This contract supersedes all prior communications, representations, or agreements, either verbal or written, between the parties. In the event there has been a written proposal supplied to the Employer by PEHP, the compliance by the Employer and its Employees with all minimum Enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of this Contract.
Paragraph headings appearing in this contract are not to be construed as interpretation of the text, but are only for the convenience of reference for the reader.

Introduction

PEHP Advantage offers quality medical care through In-Network Providers, primarily based around the Intermountain Healthcare facilities and affiliated Providers. PEHP Summit consists of predominantly IASIS, MountainStar, and University of Utah Health Care providers and facilities. In addition, PEHP has Contracted with MultiPlan to secure discounts with Provider networks outside the state of Utah. The National Access Program offers PEHP Members access to In-Network Providers outside the state of Utah in accordance with plan benefits.

The Member pays the specified Co-pay(s) at the time of service and the balance is paid according to plan benefits.
Failure to use In-Network Providers may result in a reduction or denial of benefits. PEHP will make available a current list of In-Network Providers at www.pehp.org or by contacting PEHP. PEHP reserves the right to make changes to the Provider list during a plan year.

Billing Accuracy

By reviewing Provider billings for accuracy, the Member can make certain that there are not duplicate or incorrect charges. The Member should report any possible discrepancies to PEHP's Customer Service Department. If the Member discovers an error on a medical billing that has been processed and paid, resolves the error and provides proof of the resolution to PEHP, the plan will reimburse the Member 50% of the amount of the excess charges found on the medical bill up to a maximum of $250 per occurrence.

I. Enrollment and Eligibility

Employees and their Dependents are eligible for Coverage as set forth herein.

1.1 ELIGIBILITY

Insurance coverage will be effective on the first day of the month following employment start date, provided enrollment forms are completed and filed in the District Insurance Office within 30 days of the employment start date.

Any Enrollment or Coverage changes must be done in writing, by the Employee. Changes made over the telephone are not acceptable.

An Employee and Dependents are eligible for participation and Coverage under this Plan when the following apply:

1. An Employee works 20 hours or more per week on a permanent basis for Jordan School District; or
2. Classified Part-Time Employees hired prior to July 1, 2014: Benefit eligible employees hired prior to July 1, 2014 working twenty (20) or more per week will remain eligible (grandfathered), as long as there is not break in service; or
3. Classified Part-Time Employees hired on or after July 1, 2014: Benefit eligible employees hired on or after July 1, 2014 must work a minimum of thirty (30) hours per week or six hours per contract day on average; or
4. Is a Retiree as outlined in the Jordan School District Policy Manual, DP 319 and DP 373.

1.1.1 Enrollment Period and Qualifying Event Changes

Enrollment changes during a plan year will only be allowed under the following circumstances, and require notification within 30 days of the qualifying event unless otherwise specified:

1. Divorce or legal separation (60 day notification);
2. Marriage, or change in number of dependents;
3. Change in employment status of employee, spouse, or dependent that causes loss of eligibility;
4. Dependent satisfies (or ceases to satisfy) eligibility requirements (60 day notification);

5. Change in residence that causes loss of eligibility;
6. Significant changes in company benefit plan(s) including cost change, significant coverage curtailment, additional or significant improvement of company offered benefits;
7. Change in coverage under another employer plan (including mandatory or optional change from your spouse's employer and change initiated by your spouse);
8. Loss of coverage from government or educational institution;
9. COBRA qualifying event (termination/reduction of hours, employee death, divorce/legal separation, ceasing to be a dependent);
10. Other changes resulting from a judgment, decree, or order; Medicare or Medicaid entitlement;
11. FMLA leave of absence.
11. Loss of CHIP or Medicaid eligibility; Gaining CHIP or Medicaid subsidy eligibility (60 day notification);

Coverage begins on the first day of the month after the eligibility date and when enrollment requirements are met. Coverage for Dependents begins when the Member's Coverage begins. Coverage for an eligible newborn child begins on the date of birth. Coverage for an adopted child begins on the date of placement in the home.

1.1.2 Special Enrollment

Special enrollment rights will be given to otherwise eligible but unenrolled persons (including Dependents of Employees) who have experienced a change in family status (including marriage, divorce, birth, and adoption) or loss of other insurance Coverage. If qualified under these provisions, persons may enroll for Coverage without having to wait until the annual open enrollment period. The Employee must complete a new enrollment form within 30 days of any change in Coverage or status. Following proper enrollment, Coverage will be made effective retroactive to the date of the change in family status.

Other Circumstances

Eligible Employees and/or their eligible Dependents may enroll or terminate Coverage at a time other than annual Enrollment if:

1. The eligible Employee had a permanent reduction in hours worked as certified by the Employer; or
2. On December 31 of any year if an enrolled Employee or Dependent certifies to PEHP within 15 days of the Marketplace open enrollment that the enrolled Employee or Dependent will enroll in a federal Marketplace plan at the next available Marketplace open enrollment.

Benefits will be provided in accordance with the applicable requirements of any Qualified Child Support Order (QMCSO).

1.1.3 Loss of Other Coverage

Eligible Employees and/or their eligible Dependents who do not initially enroll in Coverage may enroll at a time other than annual Enrollment if each of the following conditions is met:

1. The eligible Employee initially declined to enroll in this Coverage due to the existence of other health plan Coverage;
2. The eligible Employee stated in writing at the time on the initial Enrollment form that the Employee declined to enroll in this Coverage due to the existence of other health plan Coverage;
3. The eligible Employee and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 30 days after the date the other Coverage is lost.
4. Proof of loss of the other Coverage (Certificate of Creditable Coverage) must be submitted to PEHP at the time of application. Proof of loss of other Coverage or other acceptable documentation, must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, PEHP will accept the following:
   a. A letter from a prior employer indicating when group coverage began and ended;
   b. Any other relevant documents that evidence periods of Coverage; or;
   c. A telephone call from the other Insurer to PEHP verifying dates of Coverage.

1.1.4 Transfer of Coverage

Should Coverage be transferred from one PEHP plan to another, or should Coverage terminate and at a later date be reinstated, plan provisions for limited benefits, yearly maximum benefits, and Lifetime Limits will be maintained and be continuous from the point of transfer or termination.

When a spouse of a Subscriber enrolls on a second PEHP plan creating "dual Coverage" (a combination of two or more PEHP plans), covered services will be adjudicated in the same order as any other COB.

1.2 COVERAGE WHILE ON LEAVE

1.2.1 Military Leave

Pursuant to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, an Employee who is on military duty with a uniformed service shall be subject to the provisions of this paragraph. If the period of duty is less than 31 days, Coverage will be maintained if the Employee pays the required Employee contribution. If the period of duty is for more than 31 days, the Employee and eligible Dependents will be able to continue Coverage. The maximum Coverage period is the lesser of 24 months or the period of duty. An Employee receiving Coverage under this Section shall be required to pay 102% of the applicable premium. The

Employee will be reinstated under the Plan upon the first day of active employment; however, the Employee must complete and submit a new enrollment application with the District Insurance Office. Except for Coverage for illnesses or injuries incurred or aggravated during the performance of leave duties, no waiting period will be imposed on a returning Employee and Dependents if the period or exclusion would have been satisfied had the Employee's Coverage not terminated due to the duty leave.

1.2.2 Family and Medical Leave Act of 1993

If an Employee takes a leave of absence that qualifies as a family or medical leave under the Family and Medical Leave Act of 1993 (an "FMLA" leave), health care Coverage for the Employee and Dependents continues as long as the Employee continues to pay his/her portion of the cost of Coverage during the FMLA leave.

1.3 TERMINATION OR LIMITATION OF COVERAGE

Coverage for a Member will only terminate if the Member ceases to be eligible for benefits for the following reasons:

1. Termination of employment—if the Employee completes the contract year, Coverage will continue through July for Employees on a year-round calendar contract, through August for Employees on a traditional calendar contract, and on the last day of the month in which employment termination occurs for Employees on a fiscal year contract.
2. Dependent child turns age 26—termination date is the last day of the month in which the Dependent turns 26.
3. Dependent child (court-ordered guardianship or foster care) turns age 26 – Coverage will terminate at the end of the day prior to the 26th birthday.
4. Divorce—termination date for ex-spouse and step-children is the day prior to the date the court signed decree is filed with the court.
5. Death of the Subscriber—termination date for surviving spouse and/or Dependents is the day of the death of Subscriber.
6. Failure of the Member to make any required payroll deduction, or other authorized charges of the Plan, subject to a 30-day grace period.

It is the Subscriber's responsibility to make written notification when a Dependent is no longer eligible for Coverage. Jordan School District will not refund Payments made for ineligible Dependents. The Subscriber will be held responsible to reimburse PEHP for the claims processed beyond eligible service dates.

According to the Utah Fraud Division, anyone who fails to notify PEHP of Dependents ineligibility is committing insurance fraud, punishable by fines or imprisonment.

PEHP shall have the right to deny claims, terminate any or all Coverages of a Member, or seek reimbursement of claims paid upon the determination by PEHP and/or Jordan School District that the Member has committed any of the following:

1. Fraud upon PEHP or Jordan School District;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of this Master Policy.

1.4 EXTENSION OF BENEFITS

1.4.1 Continuation of Coverage Under Consolidated Omnibus Reconciliation Act of 1985 (COBRA)

The Public Employees Health Program (PEHP) is providing you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to temporarily continue health and /or dental coverage if you are an employee of an employer with 20 or more employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose PEHP coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions please call the PEHP Office at 801-366-7555 or refer to the Benefit Summary and/or the PEHP Master Policy at www.pehp.org.

There may be other Coverage available through the Healthcare Marketplace Exchange. Please see the Coverage Alternatives information at the end of this section.

COBRA Qualified Beneficiary

A Qualified Beneficiary is an individual who is covered under the employer group health plan the day before a COBRA Qualifying Event.

Who is Covered

Employees

If you have group health or dental coverage with PEHP, you have a right to continue this coverage if you lose coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

Spouse of Employees

If you are the spouse of an employee covered by PEHP, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose continuation coverage for yourself if you lose group health coverage under PEHP for any of the following five reasons:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

Dependent Children

A Dependent child of an employee covered by PEHP where and the Dependent is covered by PEHP the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to continuation coverage if group health coverage under PEHP is lost for any of the following six reasons:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment.
3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under PEHP; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired.

At the time of Enrollment, or anytime thereafter, the District Insurance Office can request proof of dependent eligibility. If proof of dependent eligibility is not provided, Jordan School District has the right to terminate dependent.

A child born that meets the definition of Dependent, which is born to, or adopted by, the covered employee during a period of continuation coverage is also a Qualified Beneficiary.

Secondary Event

A Secondary Event means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA coverage under certain circumstances, from 18 months to 36 months of coverage. The Secondary Event 36 months of coverage extends from the date of the original Qualifying Event.

Separate Election

If there is a choice among types of coverage under the plan, each of you who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or Dependent child is entitled to elect continuation of coverage even if the covered employee does not make that election. Similarly, a spouse or Dependent child may elect a different coverage from the coverage that the employee elects.

Your Duties Under the Law

It is the responsibility of the covered employee, spouse, or Dependent child to notify the employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health/dental plan in order to be eligible for COBRA continuation coverage. PEHP can be notified at 560 East 200 South, Salt Lake City, UT, 84102. PEHP Customer Service: 801-366-7555; toll free 800-765-7347. Appropriate documentation must be provided such as; divorce decree, marriage certificate, etc.

It is the responsibility of a Subscriber to inform PEHP if they are currently in the process of a divorce. If in the process of a divorce, a member may be prevented by court order from making changes to PEHP coverage, such as modifying or changing beneficiaries. To make changes to your coverage, you must certify that you are not a party to a Utah divorce proceeding and are not subject to an injunction/order which prevents you from modifying insurance or changing beneficiaries.

Keep PEHP informed of address changes to protect you and your family's rights, it is important for you to notify PEHP at the above address if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

In addition, the covered employee or a family member must inform PEHP of a determination by the Social Security Administration that the covered employee or covered family member was disabled during the 60-day period after the employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. (See "Special rules for disability," below.) If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform PEHP of this redetermination within 30 days of the date it is made.

Employer's Duty Under the Law

Your Employer has the responsibility to notify PEHP of the employee's death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to PEHP within 60 days of the happening of the event. When PEHP is notified that one of these events has happened, PEHP in turn will notify you and your Dependents that you have the right to choose continuation coverage. Under the law, you and your Dependents have at least 60 days from the date you would lose coverage because of one of the events described above to inform PEHP that you want continuation coverage or 60 days from the date of your Election Notice.

Election of Continuation Coverage

Members have 60 days from, either termination of coverage or date of receipt of COBRA election notice, to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again.

If you choose continuation coverage, your Employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

Premium Payments

Payments must be made by the Member retroactively to the date of the qualifying event or loss of coverage and paid within 45 days of the date of election. There

is no grace period on this initial premium. Subsequent payments are due on the first of each month with a thirty (30) day grace period. Delinquent payments will result in a termination of coverage.

The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded.

How Long Will Coverage Last?

The law requires that you be afforded the opportunity to maintain COBRA continuation coverage for 36 months, unless you lose group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. Such events may extend an 18-month COBRA continuation period to 36 months, but in no event will COBRA coverage extend beyond 36 months from the date of the event that originally made the employee or a qualified beneficiary eligible to elect COBRA coverage. You should notify the PEHP if a second qualifying event occurs during your COBRA continuation coverage period.

Special Rules for Disability

If the employee or covered family member is disabled at any time during the first 60 days of COBRA continuation coverage, the continuation coverage period may be extended to 29 months for all family members, even those who are not disabled.

The criteria that must be met for a disability extension is:

1. Employee or family member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA coverage.
3. Employee or family member must notify PEHP of the disability no later that 60 days from the later of:
   a the date of the SSA disability determination; or
   b the date of the Qualifying Event, or
   c. the loss of coverage date, or
   d. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.
4. Employee or family member must notify employer within the original 18 month continuation period.
5. If an employee or family member is disabled and another qualifying event occurs within the 29-month continuation period (other than bankruptcy of your Employer), then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Special Rules for Retirees

In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.

Continuation Coverage May Be Terminated

The law provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following reasons:

1. Your Employer no longer provides group health coverage to any of its employees.
2. The premium for continuation coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an employee).
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by PEHP that the employee or family member has committed any of the following, fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage plus 2%.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. More information regarding COBRA may be found in the PEHP Master Policy, and your Plan's Benefit Summary found at www.pehp.org.

Questions

If you have any questions about continuing coverage, please contact PEHP at 560 East 200 South, Salt Lake City, UT, 84102. Customer Service: 801-366-7555; toll free 800-765-7347.

Coverage Alternatives

There may be other Coverage options for you and your family. You are now able to buy Coverage through the Health Insurance Marketplace, which may cost less than COBRA. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you

make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Through the Marketplace you will also learn if you qualify for free or low-cost Coverage from Medicaid or the Children's Health Insurance Program (CHIP).

You have 60 days from the time you lose your job-based Coverage to enroll in the Marketplace. After 60 days your special enrollment period will end and you may not be able to enroll, you should take action right away. In addition, during an "open enrollment" period, anyone can enroll in Marketplace Coverage.

If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through a "special enrollment period." If you terminate your COBRA early without a qualifying event, you will have to wait to enroll in Marketplace Coverage until the next open enrollment period, and could end up without any health Coverage in the interim.

If your COBRA ends you will be eligible to enroll in Marketplace Coverage through a special enrollment period event, if the Marketplace open enrollment has ended. If you sign up for Marketplace Coverage instead of COBRA, you cannot switch to COBRA under any circumstances.

You can access information regarding the Marketplace at HealthCare.gov or call 800-318-2596

1.4.2 Medicare Supplement

Members, upon reaching age 65, who are no longer working, and eligible for Social Security benefits are eligible for the Public Employees Medicare Supplement Plan if either:

1. They have earned service credit with Utah Retirement Systems or are a participant with the URS 401(k) Plan and enroll:
   a. within 60 days of termination from active Coverage;
   b. within 90 days from turning age 65; or
   c. within 90 days from the date of retirement; or
2. They had PEHP medical Coverage through their Employer and enroll within 60 days of termination from PEHP active group Coverage.

II. Administration

2.1 MASTER POLICY

This Master Policy, with a complete description of benefits, is maintained by PEHP. If specific information is not addressed in this policy or the Benefits Summary section regarding eligibility for benefits or the amount payable for health benefits, a written request for Preauthorization of benefits may be submitted.

Please refer to both this Master Policy and the Benefits Summary section for Covered Services. In any conflict regarding Covered Service, the Benefits Summary supersedes the Master Policy. In all other instances, the Master Policy supersedes the Benefits Summary.

2.2 COOPERATION

Members shall cooperate fully with PEHP if and when PEHP requests such cooperation, whether in the form of providing information, providing releases for prior Medical Records, or other reasonable requests for cooperation. Failure by a Member to cooperate under this section shall be a breach of this Master Policy and may result in forfeiture of benefits or termination of Coverage.

2.3 AUTHORIZATION TO OBTAIN/RETAIN/SHARE INFORMATION

By enrolling with PEHP and accepting or receiving services and/or benefits through PEHP, all Members agree that PEHP and healthcare Providers are authorized to obtain, retain, and share information (including but not limited to sensitive medical information contained in Medical Records) necessary or reasonably believed to be necessary in order to process and evaluate claims for services rendered. PEHP will maintain the confidentiality of such information in its possession as regulated by 45 CFR 160 and 164 as amended, UCA §49-11-618 and applicable Utah State Retirement Board resolutions.

2.3.1 Requests for Information

As a condition of receiving benefits under this Master Policy, Members shall provide PEHP with all information at PEHP's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Member to provide information to PEHP at PEHP's request under this section within a reasonable time, as determined by PEHP shall be a breach of this Master Policy and may result in forfeiture of benefits, termination of Coverage, or PEHP having the right to hold payment of claims for the Member or the Member's dependents until the requested information is received by PEHP. Unless another time frame is specifically allowed in another section of this Master Policy, PEHP will only pay retroactive benefits for a limited period of time. Such retroactive benefits shall only be paid back to a) the start of the current plan year, or b) 90 days prior to the start of the current plan year if the request is made within 90 days of the current plan year. No retroactive benefits shall be paid for more than one calendar year.

2.4 MEDICAL REVIEW AND CLAIM VERIFICATION

PEHP reserves the right at its discretion to determine whether a claim is a Covered Service or to require verification of any claim for Covered Services. Considered expenses must be incurred while Member is eligible under the plan. The date the medical service is received

shall be the date medical expenses are incurred. PEHP shall not be responsible for any expenses that are not Covered Services.

PEHP may request Medical Records, operative reports, pathology reports, x-rays, photos, etc. of Member, or may require that all services be authorized through a primary care physician and/or case manager to be eligible for benefits. PEHP may review the Medical Records or have the records reviewed by qualified healthcare Providers or other qualified entities to audit claims for eligibility, Medical Necessity, and appropriateness of services within the Community Standard or usual patterns of care as determined by PEHP. Members shall have the right to appeal decisions as outlined in Title 49, Chapter 11 of the Utah Code Annotated.

Benefits are adjudicated in conjunction with the In-Network Rate, and code review systems implemented by PEHP. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

2.5 OUT-OF-STATE /OUT-OF-COUNTRY COVERAGE

Except in specified areas bordering Utah and listed on the PEHP Provider Look-up Tool, PEHP does not contract with Providers or otherwise maintain a network of Providers outside of Utah. Instead, PEHP pays out-of-state Providers a fair rate and directs members to Providers from which a fair rate can most likely be obtained. To the extent possible, PEHP minimizes balance billing for Members.

Out-of-State Emergency Services

For any out-of-Utah Emergency Services, PEHP shall pay to the Provider in accordance with the law. A Member's cost sharing responsibility shall be limited to the legally required amount that PEHP paid.

Out-of-State Non-Emergency Services

Members may not seek covered, non-emergency services outside of the state in which they live without preauthorization, nor may they move to another state for the primary purpose of seeking care in that state.

For non-Emergency Covered Services outside of Utah, PEHP directs Members to Providers for fair payment as follows:

1.. PEHP lists out-of-Utah physicians and other licensed professionals on the PEHP Provider Look-Up Tool for which a fair rate is most likely to be obtained.

2. PEHP requires Members to receive pre-authorization for out-of-Utah facility services so that PEHP can determine medical appropriateness, the likelihood of the Provider's acceptance of a fair rate, and whether another location may be preferrable.

3. PEHP determines the best option for unique care when it is not available within Utah.

4. PEHP determines that the best option for care for a member living out-of-Utah is in Utah.

PEHP makes fair payment to out-of-state providers for non-Emergency services based on:

1. The willingness of a Provider to accept a rate that is also acceptable to PEHP;

2. A multi-factored analysis of what a provider should accept as a fair rate; or

3. The Utah prevailing rate or a variation thereof using a percent of Medicare as a benchmark.

A Member may not be held responsible for any amount above the applicable cost sharing when directed by PEHP to a provider for fair payment.

A Member is not required to use a Provider to which PEHP directs them. In such cases, fair payment will be limited to the Utah Prevailing Rate at the in-network benefit.

Out-of-Country Services

Emergency Services received by a Member outside of the United States will be allowed by PEHP at the lesser of billed charges or the Utah Prevailing Rate, if the Member provides PEHP with a copy of the original foreign claim and provides PEHP with acceptable documentation of the claim. PEHP will reasonably translate the claim into English when possible and convert the charges to United States Currency.

Members may not seek covered, non-Emergency Services outside of the United States without Preauthorization. If a Member travels outside of the United States seeking coverage for any otherwise eligible medical service, medication other than those Preauthorized and approved through the PEHP Pharmacy Tourism Benefit, or Device, it will be deemed as not eligible as well as any complications arising thereof.

2.6 LIABILITY FOR SERVICES

Under the terms of this policy, PEHP will only be liable for Covered Services for which the Member is liable. Payment will not be made for any expense for which the Member is not legally bound.

2.6.1 Excess Payment by the Plan

If, at any time, payments made by PEHP with respect to Covered Services total more than the maximum amount necessary at that time to satisfy the intent of the provision, or if non-allowable services or benefits are paid in error, PEHP has the right to recover such overpayment together with all court costs and reasonable attorney fees from the Member. From the date of written notification the Member will have 30 days to make reimbursement or arrangements for repayment. If these arrangements are not made, PEHP shall have the right to cancel Coverage for non-payment and/or exercise any other rights available under law. It will be necessary for the Subscriber to re-enroll.

If, in the course of adjudication or review, a fraudulent misrepresentation or felonious claim is discovered, PEHP may deny or seek reimbursement for payments and associated costs, such as legal fees, made in association with such

claim. Disputes for resolution of this section are outlined in Title 49, Chapter 11 of the Utah Code Annotated.

2.7 MANDATORY CARE COORDINATION

Mandatory Care Coordination is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Mandatory Care Coordination, a nurse case manager will work with the Member, the Member's family, Providers, outside consultants and others to coordinate a comprehensive, medically appropriate treatment plan.

Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines.

PEHP, at its own discretion, may require a Member to obtain Preauthorization for any and all benefits in coordination with Mandatory Care Coordination, if PEHP has determined such action is warranted by the Member's claims history.

2.8 CONFIDENTIALITY

PEHP is subject to the confidentiality provisions of Utah Code Annotated §49-11-618 and provisions of 45 CFR 160 and 164, and is bound thereby. The use of Member data is for the sole purpose of administering the plan, which may include the review of claims and utilization experience of the Members.

2.9 IN-NETWORK PROVIDERS

Providers listed as In-Network Providers with PEHP are not Employees or agents of PEHP and PEHP does not control the manner in which In-Network Providers provide professional services. PEHP will not be liable or responsible for claims of malpractice or professional negligence against In-Network Providers or any healthcare professional reimbursed under PEHP programs.

2.10 BENEFIT CHANGES

Jordan School District has the right to modify or amend this policy with the written approval of PEHP, which approval shall not be reasonably withheld, provided that no such modification or amendment shall be effective until sixty (60) days after written notice of such modification or amendment has been given to the Subscriber by PEHP or by Jordan School District.

Any notice shall be deemed to have been given to and received by the Subscriber when deposited in the United States mail with first class postage prepaid and addressed to the Subscriber at the address shown in the records of PEHP.

Except as otherwise expressly stated, Jordan School District is responsible for providing sixty (60) days advance written notice to Subscribers relating to changes in benefits or procedures. PEHP will provide copies of documents to be provided to Subscribers by Jordan School District in case of a termination of the group. Jordan School District agrees to reimburse PEHP for all reasonable costs and expenses if Jordan School District fails to provide any required notice immediately upon request of PEHP and PEHP has to provide such notice.

Each Subscriber agrees to promptly notify his/her Dependents of all benefit and other plan changes.

No Member has a vested right in any particular benefit, level of care or service that supersedes the right of Jordan School District to make changes to this Master Policy. The rights and interests of Members, at any particular time, depend on the Master Policy in effect at that time.

2.11 RATE CHANGES

Rate changes may occur due to health insurance costs and Employee negotiations.

2.12 PEHP EMPLOYEE RESPONSES

Without the consent of PEHP Administration and Jordan School District, individual Employees of PEHP do not have the authority to:

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this Master Policy, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with PEHP requirements such as the use of In-Network Providers or the necessity of obtaining Preauthorizations.

Benefits under this Master Policy are determined by and limited to the provisions stated in this Master Policy. In the event PEHP and/or Jordan School District choose to honor any Coverage or pay for any service mistakenly authorized or provided, such Coverage or payment will be limited to a maximum period of not more than thirty (30) days.

2.13 NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), PEHP covers mastectomy in the treatment of cancer and reconstructive surgery after a mastectomy. If you are receiving benefits in connection with a mastectomy, coverage will be provided according to PEHP's Mandatory Care Coordination criteria and in a manner determined in consultation with the attending physician and the patient, for:

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

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Co-pay limitations consistent with those established for other benefits.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered.

All benefits are payable according to the schedule of benefits, based on this plan. Regular Preauthorization requirements apply.

2.14 NOTICE OF NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. physician, nurse midwife or physicians assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

2.15 NOTICE OF EXEMPTION FROM HIPAA

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local government employers that sponsor health plans to elect to exempt a plan from these requirements for part of the plan that is self-funded by the employer, rather than provided through an insurance policy. PEHP has elected to exempt your plan from the following requirement:

» Application of the requirements of the 2008 Wellstone Act and the 1996 Mental Health Parity Act;

The exemption from this Federal requirement will be in effect for the 2017 plan year. The election may be renewed for subsequent plan years.

HIPAA also requires PEHP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under PEHP. There is no exemption from this requirement. The certificate provides evidence that you were covered under PEHP.

2.16 NEW TECHNOLOGY

Services related to new technology occurring during a plan year require Preauthorization. The information contained herein applies only to proven and currently available services as of the date of this Master Policy.

III. Coordination of Benefits

3.1 COORDINATION OF BENEFITS WITH OTHER CARRIERS

PEHP plans will coordinate benefits with other individual, group, or HMO health insurance contracts providing Hospital, medical or surgical expense benefits, except those specifically excluded in Section 3.3 of this Master Policy. Coordination of Benefits (COB) will be administered in accordance with Utah Insurance Code rules.

The Subscriber must inform the Jordan School District Insurance Office of other medical Coverage in force by completing a Duplicate Coverage Inquiry form. If applicable, the Subscriber will be required to submit court orders or decrees. Subscribers must also keep the District Insurance Office informed of any changes in COB status throughout their Coverage with PEHP.

PEHP plans contain a non-profit provision coordinating Covered Services with other plans under which a Member is covered, including dual Coverage through PEHP, so that the total benefits payable will not exceed 100% of the Covered Service. An allowable expense is any necessary, reasonable and customary expense covered by PEHP. For purposes of COB, the maximum allowable expense per procedure will be AA, or the amount allowed by the primary carrier, per individual procedure, whichever is greater. When an in-network Provider is used, the maximum allowable per procedure is AA.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses of the secondary plan.

Prescription benefits are administered by a Contracted Pharmacy Benefit Manager (PBM). When submitting claims that are prescription medication Co-pays from another insurance plan, it is necessary to attach an itemized receipt to a PBM claim form. The PBM will reimburse the Co-pay or the PBM allowance, whichever is less.

No plan pays more than it would without the Coordination provision. When coordinating as secondary with an HMO, PPO, or Medicare, PEHP will reimburse up to Co-pay amounts that the Member is legally obligated to pay after the primary carrier has paid the claim.

If coordinating as secondary payor, PEHP will not be responsible to pay because the original primary payor denies Coverage when claim is not billed within the specified time limits.

It is the responsibility of the Subscriber to provide complete and accurate information regarding other Coverage(s) and to be sure benefits are coordinated in the proper order. The Subscriber shall submit to Jordan School District written notice of changes, additions, or termination of other Coverage. Documentation should include:

1. The other insurance company name and phone number;

2. The Subscriber/policyholder of the other plan and plan ID number;
3. Dependents covered by the other plan;
4. The type of Coverage (medical and/or dental); and
5. The effective and/or termination dates of Coverage(s).

PEHP may recover any overpayments or incorrect payments made due to incorrect COB information.

3.1.1 Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an Employee, or Subscriber, are determined before those of the plan that covers the person as a Dependent.
2. Dependent Child—Parents not Separated or Divorced.

   The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are as follows:

   a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. (The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.)

   b. If both parents have the same birthday, benefits of the plan that covered the parent longer are determined before the shorter Coverage.
3. Dependent Child—Separated or Divorced Parents.

   If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls earlier in the calendar year;

   b. Then, the plan of the spouse of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls second among Subscribers in the calendar year;

   c. Then the plan of the parent who is not ordered by divorce decree to maintain coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls third among Subscriber in the calendar year;

   d. Finally, the plan of the spouse of the parent who is not ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls last among Subscribers in the calendar year.

   Once the Dependent turns 18, PEHP must be consulted to determine the order of benefit determination as it can be affected by may circumstances. A copy of the divorce decree may be requested for file documentation.

   There are many circumstances that affect order of benefit determination. Please contact PEHP Customer Service for further clarification.

3.2 NO COB WITH OTHER TYPES OF PLANS

PEHP does not coordinate with school plans, sports plans, Accident only Coverage, specified disease Coverage, nursing home or long-term care plans, disability income protection Coverage, Veterans Administration plans, or Medicare Supplement plans.

3.3 COB WITH MEDICARE

PEHP's COB with Medicare and its status as primary or secondary payor shall be determined in accordance with applicable Medicare laws and regulations. Benefits shall be considered payable by Medicare for purposes of this provision whether or not the individual eligible for Medicare benefits has enrolled in or applied for Medicare Parts A and B, or has failed to take any other action required by Medicare to qualify for benefits, or would have received benefits payable by Medicare as if the individual received services in a facility to which Medicare would have paid benefits.

When PEHP is secondary to Medicare, benefits otherwise payable under PEHP shall be reduced so that the sum of benefits payable under PEHP and Medicare shall not exceed the total of allowable expenses of the primary plan.

3.4 AUTO INSURANCE/NO-FAULT

Any benefits eligible for payment under automobile insurance including No-fault, Personal Injury Protection, or similar Coverage required by law will be denied by PEHP, whether or not such Coverage is actually in effect. All such auto insurance benefits payable on behalf of a Member will be considered, even if such Coverage exceeds the statutory minimum required Coverage.

If a Member fails to maintain No-fault insurance on his/her own vehicle as required by law in the state they reside in, the minimum dollar amount they are required to maintain ($3,000 in Utah) for claims related to the auto injury are excluded from Coverage.

3.5 CORRECTION OF PAYMENT IN ERROR

PEHP shall have the right to pay to any organization making payments under other plans that should have been made under this Master Policy, any amount necessary to satisfy the payment of claims under this Master Policy. Amounts so paid by PEHP shall be considered benefits paid under this Master Policy, and PEHP shall be

fully discharged from liability under this Master Policy to the extent of such payments.

IV. Subrogation and Contractual Reimbursement

4.1 CONTRACTUAL REIMBURSEMENT

The Member agrees to seek recovery from any person who may be obligated to pay damages arising from occurrences or conditions caused by the person for which Covered Services are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf.

In the event that Covered Services are furnished to a Member for bodily injury or illness, the Member shall reimburse PEHP with respect to a Member's right (to the extent of the value of the benefits paid) to any claim for bodily injury or illness, regardless of whether the Member has been "made whole" or has been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

4.2 SUBROGATION

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Covered Services are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf. The Member will cooperate fully with PEHP and will sign and deliver instruments and papers and do whatever else is necessary on PEHP's behalf to secure such rights and to authorize PEHP to pursue these rights.

In the event that Covered Services are furnished to a Member for bodily injury or illness, PEHP shall be and is hereby subrogated (substituted) with respect to a Member's right (to the extent of the value of the benefits paid) to any claim for bodily injury or illness, regardless of whether the Member has been "made whole" or has been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to Subrogation is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

At the time of PEHP discovery of a possible Subrogation case, PEHP will send a Third Party Liability questionnaire to the Subscriber advising response is required within 30 days and that claims related to the incident will be held until the questionnaire is received. If not received within 12 months of the request, no payment will be made for the claims related to the incident. If received later than 90 days but less than 12 months from the request, payment will only be made for claims received in the 90 days prior to receipt of the information.

4.3 ACCEPTANCE OF BENEFITS AND NOTIFICATION

Acceptance of the benefits hereunder shall constitute acceptance of PEHP's right to reimbursement or Subrogation rights as explained above.

4.4 RECOUPMENT OF BENEFIT PAYMENT

In the event the Member impairs PEHP's reimbursement or Subrogation rights under this contract through failure to notify PEHP of potential liability, failure to keep PEHP up to date regarding any legal action or settlement with a responsible party, settling a claim with a responsible party without PEHP's involvement, or otherwise takes action that impairs PEHP's ability to recover amounts paid, PEHP reserves the right to withhold payment for any claims, and to recover from the Member the value of all benefits paid by PEHP on behalf of the Member resulting from the party's acts or omissions.

No judgment against any party will be conclusive between the Member and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

V. Claims Submission, Information and Appeals

5.1 CLAIMS SUBMISSION

When an In-Network Provider is used, the Provider will submit the claims directly to PEHP. Payment will be made directly to the In-Network Provider. It is the In-Network Provider's responsibility to ensure the claim is received by PEHP within 12 months from the date of service when PEHP is the primary payer. Claims denied for untimely filing are not the Member's responsibility. Exceptions:

a. When PEHP becomes the secondary payor, the Member is responsible to ensure timely filing from all Providers. Claims must be submitted to PEHP within 15 months from the date

of service to be eligible.

b. When the Member fails to provide accurate information regarding Medical Plan Coverage to the Provider.

c. Claims denied for untimely filing in these instances are the Member's responsibility.

When an Out-of-Network Provider is used, it is the responsibility of the Member to ensure that the claim is filed promptly and properly. PEHP accepts paper and electronic claims. Claims that are not received within 12 months from the date of service when PEHP is the primary payer, or 15 months if PEHP is secondary or further payer, will be denied. The Member will be responsible for the entire claim.

1. The CPT (Current Procedural Terminology); HCPCS (Health Care Financing Administration's Common Procedural Coding System); ICD (International Classification of Diseases) code(s) and NDC# (National Drug Code), if applicable, and the Providers required information for claims submission must be provided.
2. Regardless of services provided by the Provider, PEHP shall only be responsible for Covered Services.
3. Preauthorization must be obtained for certain procedures outlined elsewhere in this Master Policy.

Preparing a claim for PEHP:

1. The Member's Identification/Prescription card and Out-of-State Network (OSN) card (if applicable) must be presented at the first visit.
2. The Provider will have a release form that authorizes PEHP to obtain necessary information. This form must be signed by the Member.
3. Benefits are paid directly to In-Network Providers.
4. Claims from In-Network Providers must be submitted electronically. Out-of-Network Providers may submit electronically, or mail to:

   Public Employees Health Program Claims Division
   560 East 200 South
   Salt Lake City, UT 84102-2004
5. In the event that eligible services are received from a covered out-of-network Provider who holds no contract with PEHP, payment will be sent to the Member, regardless of assignment of benefits.

5.2 WHEN A MEMBER NEEDS INFORMATION

PEHP will take appropriate steps to identify a Member calling for claims information.

5.2.1 Member's Responsibilities

It is the Member's responsibility to understand benefit Limitations, Preauthorization requirements, Exclusions and choice of Providers, which may apply to the Member's circumstances. If a Member is in doubt as to benefit information, PEHP should be consulted.

The Member shall be responsible for any balance not paid by PEHP when an Out-of-Network Provider is used.

5.2.2 Request for Information by a Non-Subscriber Parent

Upon receiving appropriate documentation, PEHP may provide a custodial parent information regarding claims payment and benefit information for the covered Dependent.

5.3 CLAIMS APPEALS PROCESS

If a Member disagrees with a PEHP decision regarding benefits, the Member may request a full and fair review by completing the PEHP Appeal form located on each explanation of benefit statement, or available online at pehp.org, and returning the form to PEHP within 180 days after PEHP's adverse benefit determination. If the appeal form is not received by PEHP within 180 days, the appeal shall be denied. PEHP shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist PEHP in making a determination on the appeal. Requests for a review of claims should be sent to:

Mail

PEHP Appeals and Policy Management Department

P.O. Box 3836

Salt Lake City, UT 84110-3836

Fax: 801-320-0541

PEHP shall review and investigate the appeal. If PEHP requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have 45 days to provide the information to PEHP. Unless an expedited appeal or unless PEHP requests additional information from the Member, PEHP shall decide the appeal and inform the Member of the decision within 60 days from its receipt of the appeal form. PEHP's investigation shall include a review by the Executive Director of Utah Retirement Systems in accordance with Utah Code Annotated § 49-11-613(1)(c).

In accordance with federal law, if PEHP's decision on the appeal involved a medical judgment, a member may request an external review of PEHP's decision by completing PEHP's external review form and returning the form to PEHP. The member shall pay $25 for filing a request for an external review unless the member provides evidence to PEHP that they are indigent (unable to pay). The request for external review and the $25 fee must be received by PEHP within four months of the date of PEHP's decision. Following the external reviewer's decision, PEHP shall notify the member of the decision. If PEHP's original decision is overturned by the external reviewer, PEHP shall refund the $25 filing amount to the Member.

If PEHP's decision on the appeal did not involve a medical judgment, or if a member contests the decision of the external reviewer, a member may, within 30 days of the denial, file a written request for a formal administrative hearing before the Utah State Retirement Board's hearing officer, in accordance with the proce-

dure set forth in Utah Code Annotated § 49-11-613. The Member must file the petition to the hearing officer on a standard form provided by and returned to the Retirement Office. Once the hearing process is complete, the hearing officer will prepare an order for the signature of the Utah Retirement Board. See the Master Policy for a more complete list of definitions. Find the Master Policy at www.pehp.org or call PEHP.

VI. Additional Benefits Program

6.1 NATIONAL ACCESS PROGRAM

The National Access Program is a value added addition to PEHP's Provider Network. This program allows in-network Coverage for only the following PEHP Members: 1) Members who are living outside the State of Utah (Members who are living outside the State of Utah must notify PEHP [800-765-7347] of their out-of-state address prior to receiving Coverage); 2) Members traveling outside the State of Utah who are in need of urgent or life-threatening services while traveling (Coverage is excluded for services outside the State of Utah when a Member is traveling for the purpose of seeking medical care or treatment.); or 3) Members that require medical services that are not available in Utah and that have been Preauthorized by PEHP. In the event a provider changes status from an In-Network Provider to an Out-of-Network Provider, PEHP will continue to pay the Provider for services at the In-Network rate and benefit for covered services for members who are considered a continuing patient for a period no longer than 90 days.

How the MultiPlan card works

Locate an In-Network Provider by clicking on the Out-of-State Network Provider List link at www.pehp.org or call the toll-free number listed on the card. When medical services are received from participating Providers you must show your PEHP ID Card. If you do not present your PEHP ID Card at the time of service, PEHP cannot guarantee discounts or in-network Provider Coverage.

VII. Preauthorization

7.1 PREAUTHORIZATION

Preauthorization is the administrative process that determines the level of benefits covered for a proposed treatment plan. Preauthorization is required for certain PEHP benefits that may be subject to Limitations. Preauthorization includes submitting medical information to PEHP, describing the recommended treatment which may include patient history, ICD and CPT code(s) with descriptions, and fees listed separately for each corresponding CPT code.

The Preauthorization becomes invalid should the treatment plan or coding change, or if other ineligible services are performed and were not previously disclosed. If the Preauthorization becomes invalid, it will then be necessary to review the claim retrospectively, with no guarantee of benefits.

Preauthorization does not guarantee payment if Coverage terminates, plan benefits change, benefit limits are met, or if the actual circumstances of the services are different than originally submitted. Benefit determination is made by PEHP in accordance with all plan provisions, terms, conditions, Limitations and Exclusions of this Master Policy and eligibility at the time of service. Preauthorization is valid only for the date span specified on the authorization, even if treatment has not been completed.

If services are performed before approval is obtained, the claim will be retrospectively reviewed before payment is considered, and Member is at risk for not covered services.

Preauthorizations by an insurance carrier other than PEHP are not acceptable.

7.1.1 Written Preauthorization

The following procedures require written Preauthorization. For a complete list of services that require Preauthorization, please visit pehp.org or call 801-366-7555:

1. All covered dental Accident procedures.
2. An otherwise non-covered dental procedure performed in an outpatient facility for a patient who is over age six.
3. All transplantation services, including care following a transplant performed prior to PEHP Coverage.
4. Surgery that may be partially or wholly Cosmetic.
5. Surgeries performed in conjunction with obesity Surgery, e.g., a gastric bypass and gallbladder procedure performed during the same Hospital stay. (Obesity Surgery is not payable.)
6. Implantation of artificial devices or artificial assist devices such as LVAD.
7. New or unproven technologies.
8. Cochlear implants.
9. Molecular diagnostics (genetic testing).
10. Except for oxygen and Sleep Disorder equipment, Durable Medical Equipment (DME) over $750, any rental that exceeds 60 days.
11. Botox injections.
12. Maxillary/Mandibular bone or Calcitite augmentation Surgery.
13. All Out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life-threatening.
14. Pelvic floor therapy.
15. Wound care, except for the diagnosis of burns.
16. Intrathecal pump.
17. Spinal cord stimulators.
18. Out-of-Network Home Health.

19. Hyperbaric Oxygen Treatments.
20. Surgical procedures utilizing robotic assistance.
21. Continuous glucose monitoring supplies and Devices.
22. Hearing aids.
23. Coronary CT angiography.
24. Implantable medications, excluding contraception.
25. Dialysis when using Out-of-Network Providers.
26. Human pasteurized milk.
27. Stereotactic radiosurgery.
28. Magnetoencephalography (MEG)/ magnetic source imaging.
29. Virtual colonoscopy.
30. Transanal endoscopic microsurgery.
31. Artificial ankle prosthetic.
32. Endovenous ablation therapy (Radiofrequency or laser).
33. Manipulation under anesthesia.
34. For Providers who bill for these services separately, General Anesthesia or Monitored Anesthesia Care for standard colonoscopy or standard EGD.
35. Any Surgery for snoring.
36. Video EEG Monitoring (VEEG).
37. Breast pumps – Hospital grade.
38. Chelation therapy
39. Insulin pumps
40. Jaw surgery
41. Attended sleep studies, regardless of place of service, or unattended sleep studies performed in a facility whose payment is based on a percentage of the billed amount.
42. Vision therapy. If approved, maximum per lifetime is 12 sessions.
43. Autism Spectrum Disorder Treatment Program.
44. Electrical tumor treament fields
45. Cochlear Implants
46. Bone-Anchored Hearing Aids

7.1.2 Verbal Preauthorization

The following procedures require verbal Preauthorization by calling PEHP Customer Service at 801-366-7755 or toll free 800-753-7754:

1. Inpatient Mental Health and Substance Abuse by calling Blomquist Hale Consulting Group at 801-262-9619 or 800-926-9619.
2. Synagis/Respigam injections must be Preauthorized through Mandatory Care Coordination.
3. All inpatient maternity stays that exceed 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section.

7.2 PREAUTHORIZATION

Preauthorization is the process of notifying PEHP by telephone in advance of treatment. Preauthorization allows PEHP to review the proposed treatment for Medical Necessity, length of treatment, scope of treatment, as well as other factors. Preauthorization is required for certain services in order to receive maximum benefits.

The following services require Preauthorization by calling PEHP:

- Inpatient Hospital medical admissions at Primary Children's Medical Center, or at any hospital located in a County other than those hospitals in Salt Lake, Davis, Utah, or Weber Counties
- All inpatient Hospital Rehabilitation admissions
- Skilled Nursing Facilities
- All inpatient Mental Health and substance abuse admissions
- All inpatient out-of-network, Rehabilitation, Skilled Nursing, Mental Health, and substance abuse admissions

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VIII. Covered Benefits and Services

The information contained herein applies only to proven and currently available services as of the start of the Member's plan year.

As allowed under this Section, PEHP may pay for Out-of-Network Providers under certain plans. Please check your benefit summary for details.

Notwithstanding any other statements in this Master Policy or applicable Benefits Summary, in rare instances PEHP will not cover any amounts billed by Out-of-Network Providers that PEHP has determined have an unsafe practice record, maintain a pattern of overbilling patients, or whose main practice is to provide services that are otherwise excluded by this Master Policy regardless of whether the Out-of-Network Provider is licensed to otherwise perform PEHP Covered Services – otherwise refered to as "No-Pay Providers."

To look at the list of PEHP In-Network Providers and a list of those that PEHP will not pay, use the PEHP Provider Look-up Tool found at www.pehp.org.

If a service is covered, but otherwise limited in number of services or dollar amount, or by clinical criteria, In-Network providers may not charge the member above the contracted rate, regardless of the amount billed. In addition, for services that are always excluded either by provider type, or type of service, providers may charge any amount they wish and members may be responsible for that full billed amount.

8.1 HOSPITAL BENEFITS

See the Benefits Summary section for specific Co-pay amounts.

When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the plan year on the actual date of service billed. When Coverage terminates during a hospital stay, it will be necessary to convert to a COBRA policy to continue Coverage for the completion of the stay beyond the termination date. In cases where an implant is placed, at its discretion, PEHP may request an invoice in order to determine coverage and allowed amounts according to the plan

8.1.1 Inpatient Hospitalization

Charges for Medically Necessary inpatient Hospitalization (semi-private room, ICU, and eligible ancillaries) are payable after applicable Co-pay.

Some Hospital admissions require Preauthorization. See Section 7.2.

For out-of-area Coverage for inpatient Hospital admissions, refer to Section 2.5 of this Master Policy.

8.1.2 Outpatient Facility Benefits

Charges for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based, are payable, after applicable Co-pay. Surgical procedures typically performed in an office setting, i.e., IUD insertion or removal, Vasectomy, Urolift, require Preauthorization to be performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based.

For out-of-area Coverage for outpatient facility admission refer to Section 2.5 of this Master Policy.

8.1.3 The following services require Preauthorization by calling PEHP:

- » Inpatient Hospital Medical admissions at Primary Children's Medical Center, or at any Hospital when the stay is longer than six days
- » All inpatient Hospital Rehabilitation admissions
- » Skilled Nursing Facilities
- » All inpatient Mental Health and Substance Abuse admissions
- » All inpatient Out-of-Network, Rehabilitation, Skilled Nursing, Mental Health, and Substance Abuse admissions

To receive maximum benefits, a Member must call for Preauthorization before being admitted to a Hospital as described below:

Elective Treatment
Treatment for a medical condition that can be scheduled in advance without causing harm or suffering to the Member's health.

Urgent Treatment
Treatment for a medical condition that, if left untreated, may cause unnecessary suffering or prolonged treatment to restore Member's health.

Emergency Treatment
Treatment for a medical condition of an unforeseen nature that, if left untreated, may cause death or permanent damage to the Member's health.

Failure to call will result in a reduction or denial of benefits.

Maternity Cases
Call PEHP's WeeCare Program at 801-366-7400 or 855-366-7400.

See Section 6.2 for more information on WeeCare.

Inpatient Treatment for Mental Health and/or Substance Abuse
Call Blomquist Hale Consulting Group at 801-262-9619 or 800-926-9619. (See the Benefits Summary section for further details.)

Failure to call may result in a denial of benefits.

Out-of-area Hospital Admission
Requires Preauthorization by the Member, the physician, the Hospital, or, in an emergency, a family member.

Call PEHP at 801-366-7755 or 800-753-7754 within the time specified for the type of treatment listed above.

Failure to call will result in a reduction or denial of benefits.

8.1.4 Emergency Room Services

Medically Necessary emergency room facility services are payable after applicable Co-pay. Each follow up visit in the emergency room will require an additional emergency room Co-pay. When emergency room treatment results in an inpatient admission (within 24 hours), or an outpatient hospital service, benefits are payable as an inpatient or outpatient stay.

8.1.5 Urgent Care Facility

Medically Necessary Urgent care facility services are payable, after applicable Co-pay.

8.1.6 Limitations relating to all Inpatient and Outpatient Hospital/Facility and Emergency Room Services

1. Charges for ambulance services, physician's Hospital or emergency room visits, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Co-pays.
2. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated and only Covered Services will be payable per AA. All procedures must be disclosed for proper adjudication.
3. Inpatient confinement or Hospitalization in a Rehabilitation unit is limited to 30 days per plan year.

4. When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, PEHP may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Mandatory Care Coordination and approval by PEHP.
5. Inpatient benefits for Mental Health and/or Substance Abuse require Preauthorization. See Mental Health and Substance Abuse sections.
6. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Preauthorization through Mandatory Care Coordination.
7. Screening colonoscopies are limited to one every 10 years for Members over age 45.
8. Additional fees charged because a robotic surgical system was used during surgery are considered incidental to the base procedure and not reimbursable separately.

8.1.7 Exclusions from Coverage relating to all Inpatient and Outpatient Hospital/Facility and Emergency Room Services

1. Ineligible Surgical Procedures or related Complications.
2. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
3. Take-home medications., unless legally required and approved by PEHP.
4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational Therapy.
7. Autologous (self) blood storage for future use.
8. Hospital charge while on "leave of absence" from the Hospital.
9. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP plan, and the transplant is eligible.
10. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
11. Custodial Care and/or maintenance therapy.
12. Major screening procedures without specific diagnosis, including but not limited to:
    a. CT scan.
    b. MRI/MRA.
13. Take home medications.
14. Mastectomy for gynecomastia.
15 Treatment programs for enuresis or encopresis for Members age 18 and over.
16. Services, procedures, medications, or devices received at or from an Out-of-Network birthing center.
17. Inpatient Provider visits are payable only in conjunction with authorized inpatient days.
18. Ancillary services performed during an unauthorized or otherwise non-Covered stay or visit

8.2 SURGICAL BENEFITS

See the Benefits Summary section for specific Co-pay amounts.

Medically Necessary Surgical Procedures are payable, after applicable Co-pay when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility. Surgical procedures typically performed in an office setting, i.e., IUD insertion or removal, Vasectomy, Urolift, require Preauthorization to be performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based.

PEHP pays for an assistant surgeon when Medically Necessary. Services of a co-surgeon, when required and in the absence of an assistant surgeon, are payable up to the combined total amount eligible per AA for the surgeon and an assistant's fee, divided equally.

PEHP pays a Global Fee for maternity charges for normal delivery, C-section, Complications, and miscarriage. With exception of the pre-natal lab charge and RhoGam injection, Global Fee benefits are payable at time of delivery. If the Member changes physicians during pregnancy or changes Coverage prior to delivery, benefits will be paid for services rendered according to the applicable procedure code as described in the AMA CPT manual. Applicable Co-pays will apply for the specific service(s) rendered. If Coverage under PEHP terminates during a pregnancy and Member wishes Coverage for delivery, continued Coverage through COBRA must be purchased to receive those benefits.

Services, procedures, medications, or devices received at or from an Out-of-Network birthing center are not covered.

8.2.1 Second Opinion and Surgical Review

A second opinion evaluation for Surgery is payable (office consultation only). Available Medical Records, including x-rays, should be forwarded to the Provider for the second opinion evaluation.

8.2.2 Limitations relating to Surgery

1. Multiple Surgical Procedures during the same opera-

tive session are allowable at 100% of In-Network Rate for the primary procedure and 50% of In-Network Rate for all additional eligible procedures. Incidental procedures are excluded.

2. Surgical benefits are payable based on Surgical Package Fees to include the Surgery and post-operative care per CPT and RBRVS guidelines.
3. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated per In-Network Rate and CPT guidelines for primary and secondary procedures. Only Covered Services will be payable. Provider's Preauthorization must disclose all proposed procedures and implantable Devices to allow for accurate adjudication.
4. Covered Services for oral Surgery are limited to the treatment of an Accidental injury; the removal of tumors and cysts; incision of sinuses, salivary glands or ducts; frenectomy; incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of the teeth.
5. Breast Reconstructive Surgery is a Covered Service if performed within five years of a mastectomy, and within three years of the initial breast reconstruction.
6. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, PEHP may allow payment for the standard Calcitite placement towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas are not eligible.
7. Additional fees charged for a robotic surgical system used during surgery are considered incidental to the base procedure and will not be reimbursed separately.
8. Dental services, not including bleaching, orthodontia, or the replacement/repair of dental appliances, are covered only in limited circumstances when pre-authorized by PEHP:
   a. When the result of an Accident, so long as the need for dental services or treatment was diagnosed, recommended, or received for the injury at the time of the Accident; and
   b. To treat congenital Oligodontia (absence of 6 or more teeth) or Anodontia (absence of all teeth) and limited as follows:
      i. Maxillary, mandibular and/or orthognathic procedures, including anesthesia, only when medically necessary to prepare for dental implants; and
      ii. One implant and one crown per congenitally missing or severely compromised, adult-size tooth (but no replacement for missing wisdom teeth or baby teeth) in a lifetime.

8.2.3 Exclusions from Coverage relating to Surgery

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future Complications.
4. Any service or Surgery that is solely for Cosmetic purpose to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
   a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes; and
   b. Reconstructive Surgery made necessary by an Accidental injury or illness in the preceding five years.
   c. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years.
5. Assisted reproductive technologies: invitro fertilization (IVF); gamete intra fallopian tube transfer (GIFT); embryo transfer (ET); zygote intra fallopian transfer (ZIFT); pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
6. Surgical treatment for correction of refractive errors.
7. Additional fees charged because a robotic surgical system was used during surgery are considered incidental to the base procedure and not reimbursable separately.
8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible.
9. Reversal of sterilization.
10. Gender reassignment surgery requires Preauthorization.
11. Rhytidectomy.
12. Dental services, except those listed in previous section.
13. Complications as a result of not covered or ineligible Surgery, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
14. Injection of collagen, except as approved for

urological procedures.

15. Lipectomy, abdominoplasty, panniculectomy, repair of diastasis recti, unless any of these procedures are medically necessary to treat an unintended adverse event of an eligible surgery.
16. Sperm banking system, storage, treatment, or other such services.
17. Non-FDA approved or Experimental or Investigational procedures, medications and devices.
18. Hair transplants or other treatment for hair loss or restoration.
19. Chemical peels.
20. Treatment for spider veins.
21. Liposuction.
22. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
23. Chin implant, genioplasty or horizontal symphyseal osteotomy.
24. Unbundling or fragmentation of surgical codes.
25. Any Surgery solely for snoring.
26. Otoplasty.
27. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
28. Surgical treatment for sexual dysfunction.
29. Subtalar Implants.
30. Mastectomy for gynecomastia.
31. Elective home delivery for childbirth, including any certified nurse midwife, MD or DO charges if delivered at home.
32. Surrogate pregnancy or charges for being a gestational carrier.

8.3 ANESTHESIA BENEFITS

See the Benefits Summary section for specific Co-pay amounts.

The charges for Medically Necessary anesthesia administered by a Provider (MD or CRNA) in conjunction with Medically Necessary Surgery are payable, after applicable Co-pay.

8.3.1 Limitations relating to Anesthesia

1. Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. Exceptions:
   a. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
   b. Anesthesia performed by an oral surgeon in conjunction with an eligible medical surgical procedure.
2. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, anesthesia benefits will be prorated and only Covered Services will be payable per AA. All procedures must be disclosed for proper adjudication.
3. Anesthesia for labor and delivery are payable on a sliding scale with one base rate (first hour— full time, second hour—half time, quarter time for every hour thereafter).
4. An epidural block during labor is not payable to the OB Provider in addition to an anesthesiologist fee.
5. Anesthesia charges relating to dental procedures for Members over age six may be covered with Preauthorization.
6. For Providers who bill for these services separately, General Anesthesia or Monitored Anesthesia Care for standard colonoscopy or standard EGD, if a Member does not have an ASA score of P3 or higher, or a Mallampati score of III or higher.
7. Manipulation under anesthesia for knees and shoulders requires written Preauthorization through Mandatory Care Coordination.

8.3.2 Exclusions from Coverage relating to Anesthesia

1. Anesthesia in conjunction with ineligible Surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care or on-call time for consultant.
4. Additional charges for supplies, medications, equipment, etc.
5. Manipulation under anesthesia for any body part other than knees or shoulders.

8.4 MEDICAL VISIT BENEFITS

See the Benefits Summary section for specific Co-pay amounts.

Medically Necessary medical visits, including visits in the Provider's office, emergency room, Hospital, or the Member's home, are payable, after applicable Co-pays.

PEHP pays for other outpatient or office services such as: chemotherapy, office Surgery, labs and x-rays, blood "factor" replacement, etc., after applicable Co-pays.

8.4.1 Limitations relating to Medical Visits

1. Outpatient and home physical therapy, occupational therapy, and pelvic floor therapy are limited to 20 combined visits per plan year. No Preauthorization required. A maximum of 10 additional physical therapy visits may be approved for a second orthopedic surgery in a plan year and requires Preauthorization. Benefits allow up to three units per visit depending on the Provider's contract terms or if performed by an Out-of-Network Provider, or are based on a per diem rate. See applicable Benefits Summary for plan limits.

2. Only one medical, psychiatric, chiropractic, physical therapy or osteopathic manipulation visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same-day visits by a multi-disciplinary team are eligible with applicable Co-pay(s) per Provider.
3. Covered Services for TMJ/TMD/Myofacial Pain are limited to the following services: initial diagnostic exam, TMJ/TMD radiographs, range of motion measurements, TMJ/TMD appliance and appliance adjustments, and physical therapy. Benefits are limited to a $500 Lifetime Maximum.
4. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative or if only covered through the Specialty Medication Program.
5. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these medications may be required to be obtained through the Specialty Medication Program. No benefits are payable for prophylactic purposes or other diagnoses.
6. Speech therapy by a qualified speech therapist is payable up to 60 visits per lifetime.

   Therapy or evaluation provided by speech therapists for dysphagia (difficulty in swallowing) is payable separate from the speech therapy limit as a medical visit.
7. Chiropractic visits are covered up to a maximum of 20 visits per plan year. Benefits allow up to two modalities per visit.
8. Voice therapy for selected criteria. Preauthorization is required. When approved, maximum benefit is 12 visits per lifetime.
9. Medical services to treat or diagnose enuresis and/or encopresis as a physical organic illness are eligible on an outpatient basis. If determined to be psychological, outpatient Mental Health benefits are payable.
10. "After hours" and/or "holidays" are payable only when special consultation is Medically Necessary beyond normal business hours or "on call" or shift work requirements.
11. Cardiac Rehabilitation, Phase 2, is payable following heart attack, cardiac Surgery, severe angina (chest pain), etc. up to a maximum of 20 visits per plan year.
12. Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery is payable up to a maximum of 20 visits per plan year.
13. Eligible medical management to monitor use of psychotropic medications is considered a medical benefit.
14. Examinations for hearing aids are eligible only when the hearing aid is eligible.
15. Chelation therapy requires Preauthorization.
16. Predictive genetic counseling except in conjunction with the Affordable Care Act (Preventive Services under Section 6.14) or as Medically Necessary, as determined by PEHP.
17. Compounding fees or materials require Preauthorization and are only covered if one or more if the following conditions are met:
    a. There is not a commercially available dosage form to meet the member need.
    b. The requested product is covered by PEHP, FDA approved, and recommended for the condition.
    c. The member is unable to use alternate routes of administration.
    d. Commercially available dosage forms cannot be reasonably altered to meet the member need.
    e. The member has a condition that will result in significant morbidity if left untreated by the compounded product.

    Whether these conditions are met is at the sole discretion of PEHP.

18 Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection are considered inclusive to the injection.

19. Vitamins are only covered in the following limited circumstances and only if medically necessary:
    a. Vitamins listed as preventive services under the Affordable Care Act (Preventive Services under Section 6.14).
    b. Vitamin K only when administered at birth or when used as an antidote to Warfarin.
    c. Injectable vitamin B-6 when received for alcohol withdrawal and administered in a hospital.
    d. Injectable vitamin B-12 for the treatment of pernicious anemia.
    e. Injectable B-12 for rare conditions (e.g. post gastrectomy, reverse neurological effects of a deficiency, etc.) as solely determined by PEHP, and only after failure of oral regimens. Coverage of vitamin B12 injections is excluded for fatigue, low energy or similar indications.
    f. Multivitamins when received in total parenteral nutrition and the member is unable to take food or other supplements by mouth.
    i. Prenatal vitamins when associated with pregnancy and listed in the Preferred Drug List.

8.4.2 Exclusions from Coverage relating to Medical Visits

1. Hospital visits the same day as Surgery or following a Surgical Procedure except for treatment of a diagnosis unrelated to the Surgery.
2. Services for weight loss or in conjunction with weight loss programs regardless of the medical indications except as allowed under the Affordable Care Act Preventive Services.

3. Acupuncture treatment.
4. Dental services, except those listed in previous section.
5. School, work, or military examinations, including lab and x-ray.
6. Charges in conjunction with or related to ineligible procedures, medications, or devices.
7. Chiropractic, physical or occupational therapy primarily for maintenance care.
8. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, driver's evaluation or training, developmental delay and Recreational Therapy, unless authorized by PEHP for the treament of Autism.
9. Speech therapy for educational purposes or delayed development, or speech therapy that does not qualify within the criteria previously stated in Limitations. Speech therapy following chronic otitis media is not eligible for Coverage.
10. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school.
11. Hypnotherapy or biofeedback.
12. Hair transplants or other treatment for hair loss or restoration.
13. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD or myofacial pain.
14. Take home medications charged by the Provider's office.
15. Screening for developmental delay or child developmental programs.
16. Rolfing or massage therapy.
17. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
18. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
19. Care, treatment or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including medications.
20. Injections (including the office visit) when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.
21. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations or sports physicals, or for legal purposes such as custodial rights, paternity suits, etc.
22. Visits in conjunction with subtalar implants; palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. (See the Benefits Summary section for Covered Services.)
23. Cardiac rehabilitation, Phases 3 and 4, and/or pulmonary rehabilitation, Phase 3.
24. Fitness programs or training.
25. Child birth education.
26. Topical hyperbaric oxygen treatment.
27. Treatment for infertility.
28. Services, procedures, medications, or devices received at or from a birthing center.
29. Any services performed by or referred by a non-covered Provider.
30. Administration fees for non-Eligible injections or infusions.

8.5 DIAGNOSTIC TESTING, LAB AND X-RAY BENEFITS

See the Benefits Summary section for specific Co-pays.

Benefits for Medically Necessary laboratory, x-ray, CT, MRI, MRA, and ultrasound services are payable. A fee for transportation of x-ray equipment is payable when appropriate.

Lab and x-rays in conjunction with office Surgery are payable after applicable Co-pays.

8.5.1 Limitations relating to Diagnostic Testing, Lab and X-ray

1. Attended sleep studies, regardless of place of service, or unattended sleep studies performed in a facility whose payment is based on a percentage of the billed amount are payable up to a maximum benefit of $2,000 in a three-year period and require Preauthorization.
2. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.
3. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan and the transplant is eligible.
4. Preauthorization is required for Genetic Testing or Molecular Diagnostics related to screening or evaluating a Member for a condition. In order to be covered, at a minimum, Molecular Diagnostic or Genetic Testing must be used to diagnose or evaluate a course of treatment for the Member, and not solely for family planning or screening. PEHP may require that these services be obtained from a designated lab, vendor, facility or location for coverage.
5. Drug screening, up to 2 times in a 30-day period.

6. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.

8.5.2 Exclusions from Coverage relating to Diagnostic Testing, Lab and X-ray

1. School, work, or military exams.
2. Charges in conjunction with or related to ineligible procedures, medications, or devices.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of medical indications.
5. Epidemiological counseling and testing.
6. Unbundling of lab charges or panels.
7. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
8. Hair analysis, trace elements, or dental filling toxicity.
9. Assisted reproductive technologies, including but not limited to: invitro fertilization (IVF); gamete intra fallopian tube transfer (GIFT); embryo transfer (ET); zygote intra fallopian transfer (ZIFT); pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
10. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
11. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.
12. Chromosomal Microarray Analysis (CMA) for Autism Spectrum Disorder.
13. Whole exome and whole genome sequencing for the diagnosis of genetic disorders, unless pre-authorized by PEHP at a children's undiagnosed clinic.
14. Any genetic tests from direct-to-consumer labs or confirmatory tests resulting from such result.

8.6 MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Benefits are limited per plan year. See the Benefits Summary section for details.

When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the plan year on the actual date of service billed. When Coverage terminates during a hospital stay, it will be necessary to convert to a COBRA policy to continue Coverage for the completion of the stay beyond the termination date.

An Employee Assistance Program (EAP) is available to all Members. The EAP services are provided by Blomquist Hale Consulting Group. Some services not covered by the medical benefit plan are available at no cost to Employees (e.g., marriage and family counseling, financial and legal problems). Daytime and evening appointments can be scheduled by calling the EAP office at 801-262-9619 or toll free 800-926-9619. Crisis situations are responded to seven days per week, 24 hours a day. The EAP office is located at 860 East 4500 South, Suite 202, Salt Lake City, Utah.

Referrals are required in order to receive Mental Health and substance abuse services. If the Member seeks Mental Health and substance abuse treatment without an EAP referral, benefits will be denied.

EAP referrals are valid only for the Mental Health Provider specified on the referral. The Member must contact the EAP if a change of Provider is made, even if the current Provider requests the change.

All services received through the EAP will be held in strict confidence. The EAP will not release the names of Members using the EAP service to the District Insurance Office.

8.6.1 Facility and Hospital Services

Medically Necessary services from Contracted Hospitals, inpatient treatment centers, day treatment facilities or intensive outpatient programs are payable after applicable Co-pays and must be Preauthorized through the EAP. (See the Benefits Summary section for further details.)

Failure to Preauthorize will result in a denial of benefits. Charges for the full Hospital stay will be prorated into a per diem rate, or as Contracted with specific Providers, for adjudication of daily benefits.

Day treatment or intensive outpatient programs (IOP) will be paid according to the applicable benefits summary under the inpatient benefit.

Electro Convulsive Therapy (ECT) is eligible under Medical benefits.

Eating disorders such as anorexia and/or bulimia, are payable under medical benefits, while Life-threatening, as determined by PEHP. When condition is no longer Life-threatening benefits are payable under Mental Health and require Preauthorization.

8.6.2 Inpatient Provider Visits

Eligible hospital visits are payable after applicable Deductibles and Coinsurance.

8.6.3 Outpatient Provider Visits

Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible and may require Preauthorization through the appropriate agency. See applicable Benefits Summary for further details.

Eligible neuropsychological evaluations and testing are payable as medical benefits.

Eligible medical management to monitor use of psychotropic medications is payable as a medical benefit.

8.6.4 Limitations relating to Mental Health and Substance Abuse

1. Benefits for group family counseling will apply to the primary patient's yearly limit. Benefits will not be considered separately for each individual family Member.
2. Inpatient Provider visits are payable only in conjunction with authorized inpatient days.
3. Only one visit per Provider of the same specialty per day is payable.

8.6.5 Exclusions from Coverage relating to Mental Health and Substance Abuse

1. Outpatient treatment for Mental Health and/or substance abuse without Preauthorization.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.
5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Tobacco abuse.
11. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
12. Drug screening, up to 2 times every 30 days.
13. Drug confirmatory laboratory tests, up to 2 codes every 30 days.
14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

8.7 AMBULANCE BENEFITS

See applicable Benefits Summary for specific Co-pays. Benefits for eligible ambulance services, including air transport, are payable after applicable Co-pay.

8.7.1 Limitations relating to Ambulance Benefits

1. Benefits are only eligible when ambulance services are necessary due to a medical emergency and only to transport to the nearest Hospital where the appropriate level of care is available.
2. Benefits will be payable for air ambulance only in Life-threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where the appropriate level of care is available.
3. Non-Emergency Mental Health transportation are eligible at contraced rates to the nearest facility where the appropriate level of care or type of treatment needed is available.
4. All facility to facility transfers are subject to review by PEHP.
5. A determination of what conditions constitute an "Emergency" will be solely determined by PEHP.
6. Air or water ambulance charges will be payable to the nearest facility able to treat the Member if the emergency is considered Life-threatening by PEHP.
7. Ground transportation to a Member's home only if the transfer is to facilitate the Member's end of life care or Hospice services must be Preauthorized by PEHP.

If emergency is considered to be non-Life-threatening by PEHP, otherwise eligible air or water ambulance charges will be payable at ground transport rates.

8.7.2 Exclusions from Coverage relating to Ambulance Benefits

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.
3. After-hours charges.
4. Charges for ambulance waiting time.

8.8 HOME HEALTH AND HOSPICE CARE BENEFITS

See the Benefits Summary section for specific Co-pays and Preauthorization requirements.

8.8.1 Limitations relating to Home Health and Hospice Care Benefits

1. Total Enteral Nutrition (TEN) formula must be obtained through the pharmacy card.
2. A home visit by an LCSW is payable from outpatient Mental Health benefits. See the Benefits Summary section for details.
3. Skilled Nursing visits are subject to plan Limitations. See applicable Benefits Summary for details.

8.8.2 Exclusions from Coverage relating to Home Health and Hospice Care

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available

to perform such services. This exclusion applies even when services are recommended by a Provider.

2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral Nutrition, unless obtained through the pharmacy card.
9. Skilled Nursing visits for administration of non-covered medications or related to other non-covered services under the plan.

8.9 ADOPTION BENEFITS

An Indemnity Benefit for Adoption in the amount of $2,500 shall be available to the Member when all of the following conditions are met:

1. The Member's coverage is in effect on the date a newborn child's adoption is final.
2. The Member is enrolled in the Plan for more than three consecutive months and the child is 90 days of age or younger.
3. The Member submits a written request for the Indemnity Benefit for Adoption along with proof of finalized adoption. The written request must contain the child's name, date of birth, and a statement regarding any other health Coverage of the adoptive parent(s). The written request shall be addressed to the following address:

   Public Employees Health Program
   560 East 200 South
   Salt Lake City, Utah 84102-2004

4. In the event of adoption of more than one child (for example, twins or siblings), the Indemnity Benefit for Adoption applies for each child adopted.
5. In the event the Member and/or the Member's spouse is covered by more than one health benefit plan, the Indemnity Benefit for Adoption shall be prorated between or among the Plans so that the full amount provided by both or all of the Plans does not exceed $2,500.

The Adoption benefits eligible under the Benefit Summary are the maximum (but not the minimum) benefits PEHP will allow per adoption, even if the Member is enrolled in more than one plan (Dual Coverage), or is also insured by another health insurance policy.

8.9.1 Exclusions from Coverage relating to Adoption Benefits

1. Expenses incurred for the adoption of nieces, nephews, brothers, sisters, grandchildren, cousins, stepchildren, children of domestic partner or in-laws of any of the above.
2. Transportation, travel expenses or accommodations, passport fees, translation fees, photos, postage, etc.
3. Living expenses, medical expenses, food, and/or counseling for the birth mother.

8.10 PRESCRIPTION MEDICATION BENEFITS

See applicable Benefits Summary for specific Co-pays. The Express Scripts pharmacy benefit provides pharmacy and injectable Coverage through our pharmacy network.

The Express Scripts Pharmacy and Specialty Medication Benefit is categorized by the following tiers:

Tier 1: Generic medications that are available at the lowest Co-pay.

Tier2: Preferred brand name medications that are available at the intermediate Co-pay

Tier 3: Non-preferred brand name medications that are available at the highest Co-pay.

Tier 4: Specialty drugs are both generic and brand name medications that are used to treat complex conditions that are available at the highest Co-pay.

Go to www.express-scripts.com or contact Express Scripts Customer Service Representative for the tier placement of your medication.

Members will receive a pharmacy Identification card upon Enrollment in the Express Scripts Pharmacy program. The Identification card will only list the Subscriber's name but will provide Coverage for each enrolled family Member. Members need to present their pharmacy card or provide their Identification number to a participating pharmacy along with an eligible prescription and any applicable Co-pay to receive their prescription medication.

8.10.1 Out-of-area Prescriptions or Other Cash Purchases

If a Member pays cash for any prescription purchase (except for prescriptions purchased out of the country), the Member must submit an itemized receipt to Express Scripts Health for reimbursement. The Member will be reimbursed the negotiated discount cost minus the Plan Co-pay.

8.10.2 Covered Formulary Medications

The following are covered benefits unless listed as an exclusion

1. Federal Legend medications
2. State Restricted Medications
3. Compound Medications if all ingredients are covered
4. Insulin
5. Needles and Syringes for administering Diabetic medications
6. OTC Diabetic Supplies (except Glucowatch Products)

7. Oral (except Emergency Contraceptives), Transdermal, Intravaginal and Injectable Contraceptives – allowed up to a 90 day supply
8. Seasonale up to a 91 day supply
9. Inhaler Assisting Devices
10. Propecia
11. Liquid Pediatric Fluoride Vitamin Drops up to 50 days
12. ACA Preventive Medications
13. Smoking Deterrents
14. Contraceptives Emergency Kits (e.g. Preven, Plan B)

8.10.3 Limitations relating to Prescription Medication Benefits

The following are Limitations of the policy:

1. Medication quantities, dosage levels and length of therapy may be limited to the recommendations of the manufacturer, FDA, clinical guidelines, or Express Scripts' Pharmacy and Therapeutics Committee.
2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting.
3. Inhalant spacers are limited to one unit per calendar year.
4. Smoking cessation products may be covered up to a 6 month maximum benefit on a rolling 2 year basis. Coverage may also require participation in an approved counseling program.
5. A medication in a different dosage from or delivery system that contains the same active ingredient as already covered medication may be restricted from Coverage.
6. Express Scripts may classify an FDA approved generic medication as non-Preferred or not covered when directed by the Pharmacy and Therapeutics Committee.
7. When medication is dispensed in two different strengths or dosage forms, a separate Co-pay will be required for each dispensed prescription.
8. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation.
9. Medication quantities and availability may be restricted to a lower allowed day supply when a manufactures' package size cannot accommodate the normal allowed pharmacy benefit day supply.
10. If a medication is packaged in a day supply that is greater than a 30-day or 90-day supply, the Member's out-of-pocket responsibility may require a Co-pay for each 30-day supply of the anticipated duration of the medication.
11. Cash paid and Coordination of Benefits claims will be subject to Express Scripts' Preauthorization, step therapy, benefit Coverage and quantity levels. Express Scripts will reimburse up to Express Scripts' Contracted rate and Express Scripts' benefit rules.
12. Express Scripts will have the ability to limit the availability and filling of any medication, Device or supply when the medication is susceptible to misuse. The Pharmacy or Case Management Department may require the following tools:
    a. Require prescriptions to be filled at a specified pharmacy.
    b. Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by Express Scripts or PEHP Case Management.
    c. Obtain Services and medications from only a specified Provider.
    d. Require participation in a specified treatment for any underlying medical condition.
    e. Require completion of a medication treatment program.
    f. Adhere to a PEHP limitation or program to help reduce or eliminate medication abuse or dependence.
    g. Deny medications or quantities needed to support any dependence, addiction or abuse if a Member misused the health care system to obtain medications in excess of what is Medically Necessary.
13. Fluoride tablets are limited to children up to the age of 12 years old.
14. Enteral formula required Preauthorization and is limited to the pharmacy network for Coverage.
15. Members must use Express Scripts' mail order facility for 90-day Coverage.
16. Retail and mail order prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used. Twenty-three days must pass at a local pharmacy and 68 days at the mail-order facility before a prescription can be refilled.
17. A separate Co-pay may be required if Federal or state law, clinical guidelines, Express Scripts quantity levels or manufacturer's package size requires a prescription to be dispensed in a quantity less than a 30 or 90-day supply

8.10.4 Exclusions from Coverage relating to Prescription Medication Benefits

The following are excluded from coverage unless specifically listed as a benefit under "Covered Medications".

1. Non-Federal Legend Medications
2. Contraceptive jellies, creams, foams
3. Glucowatch Products
4. Allergy Serums

5. Retin-A / Avita (creams only)
6. Anti-Obesity Medications
7. Fertility Agents
8. Ostomy Supplies
9. Yohimbine
10. Therapeutic devices or appliances
11. Mifeprex
12. Medications whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
13 Medications needed to participate in any medication research or medication study.
14. Biologicals, Immunization agents or Vaccines
15. Blood or blood plasma products
16. Medications labeled "Caution-limited by Federal law to investigational use", or experimental medications, even though a charge is made to the individual.
17. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Medication or Medical Service for which no charge is made to the member.
18. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
19. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
20. Charges for the administration or injection of any medication.
21. A prescription that exceeds any quantity levels or step therapy disclosed on Express Scripts' Preferred Medication List or website.
22. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
23. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old).
24. Replacement of lost, stolen or damaged medications.
25. Non-approved indications determined by Express Scripts' Pharmacy and Therapeutics Committee and the Jordan School District Master Policy.
26. Medications for athletic and mental performance.
27. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by Express Scripts' Therapeutics Committee.
28. Oral infant and medical formulas
29. Diagnostic agents
30. Over-the-counter medications and products unless listed in Express Scripts' Preferred Medication List
31. Take-home prescriptions from a Hospital or Skilled Nursing Facility.
32. Medications used for Cosmetic indications.
33. Medications purchased from non-participating Providers over the Internet.
34. Nasal immunizations unless listed in the Express Scripts' Preferred Medication List.
35. Medications for the treatment of nail fungus.
36. Medications for sex change operations.
37. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services.
38. Hypodermic Needles
39. Oral and nasal antihistamines for allergies
40. Medications obtained outside the United States that are not for Urgent or emergency use.
41. Medications for the treatment of infertility unless listed in the Preferred Medication List.
42. An additional medication that may be considered duplicate therapy by the FDA or Express Scripts.
43. All erectile dysfunction/impotence medications both injectable and oral, including Addyi.
44. Medications prescribed by non-covered Provider types or non-payable Providers.

8.10.5 Preauthorization for Prescription and Specialty Medications

Express Scripts has chosen specific prescription medications, Specialty medications and injectable require Preauthorization. These medications were chosen due to their high potential for safety issues, adverse reactions, contraindications, misuse, opportunity to use first line therapy and cost. Go to www.express-scripts.com or contact Express Scripts Customer Service for a complete listing of medications that require Preauthorization.

To obtain Preauthorization, a Member's physician may contact Express Scripts' pharmacy Preauthorization phone line. Approval or denial will be communicated to the Provider's office. Members may also phone Express Scripts' Customer Service Department for a status of the physician's request. Preauthorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and Preauthorization requirements.

8.10.6 Quantity Levels and Step Therapy

Medications may have specific limits on how much

of the medication Members can receive with each prescription or refill to ensure that Members receive the recommended and appropriate dose and length of therapy. The Pharmacy Benefit Manager and Therapeutics Committee establishes quantity levels based on criteria that includes the maximum dosage levels indicated by the medication manufacturer, duration of therapy, FDA, and the cost of the medication. Members must obtain Preauthorization for any quantity that exceeds a quantity limit. Go to www.express-scripts.com for a complete list of medications that require a quantity level.

For some disease states and some medication categories, one or more medications must be tried before a medication will be covered under the pharmacy or injectable benefit.

Step therapy ensures that a Member receives the most clinically appropriate and cost effective medication. Step therapy is based on current medical studies, generic availability, cost of the medication and FDA recommendations.

8.10.7 Pharmacy Coordination of Benefits with Other Carriers

Express Scripts will coordinate pharmacy benefits with other insurance carriers when claims meet the requirements listed.

If Express Scripts is the secondary carrier, Members must purchase their prescription medications through their primary insurance carrier. Express Scripts will coordinate Coverage of eligible Co-pays and unpaid claim amounts if the pharmacy claim meets Express Scripts' pharmacy benefit requirements, Coverage rules, Preauthorization requirements and quantity levels. Members must submit an original itemized receipt (a pharmacy printout is not a valid receipt) and a claim form to Express Scripts. If the primary insurance did not provide any Coverage of the claim, the Member must pay for the prescription at the point of sale and provide an explanation of payment or denial from their primary insurance carrier. Members may obtain a claim form at www.express-scripts.com, or by contacting Express Scripts' Customer Service Department. Reimbursement will not exceed Express Scripts' normal discounted rate or any Limitation required by the pharmacy benefit. If the primary insurance requires a Deductible or out-of-pocket maximum, Express Scripts will recognize the pharmacy claim as unpaid by the primary insurance until the Deductible or out-of-pocket maximum is met. Express Scripts will administer the claim as a primary insurance and reimburse minus the patient's required retail Co-pay.

8.10.8 Out-of-Area Prescriptions or Other Cash Purchases

If Members are traveling outside the service area, they may contact Express Scripts' Customer Service Department for the location of the nearest Contracted pharmacy in the United States. In emergency situations, Members may pay for a prescription and mail a reimbursement form along with a receipt to Express Scripts for reimbursement. Reimbursement forms may be obtained from www.express-scripts.com.

Urgent and emergent medications will be covered if obtained outside the United States when the medication or class of medication is covered under the Express Scripts Pharmacy or Specialty benefit. Express Scripts will determine the Urgent or emergent status of each claim submitted for reimbursement. Cash paid and out-of-area claims will be subject to Express Scripts' Preauthorization requirements and step therapy and quantity levels. Express Scripts will reimburse up to our usual and customary contract rate and benefit rules minus the required Co-pay.

8.10.9 Specialty and Injectable Medications

Specialty and injectable medications are typically bio-engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. Express Scripts may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

Our specialty pharmacy, Accredo, will coordinate with you or your physician to provide delivery to either your home or your provider's office. Sometimes Specialty Medications may be available through both our specialty pharmacy and through your provider's office or facility. Preauthorization may be required, and you may also have a separate out-of-pocket maximum.

Visit www.express-scripts.com or call Express Scripts for a complete list of the medications required to be dispensed through our designate specialty pharmacy or those that are subject to a specialty benefit co-pay.

8.10.10 Prescriptions by Mail

Members can purchase a 90-day supply of a maintenance medication at Express Scripts' mail-order facility. Maintenance medications are the only medications available through Express Scripts' mail-order program. Maintenance medications are prescribed to treat chronic conditions as defined by the PDA or Express Scripts.

Examples of maintenance medications available through the mail-order program include:

a. Diabetes medications
b. Anticonvulsants
c. Birth control pills
d. Blood pressure medications
e. Asthma medications
f. Antidepressants

Examples of medications not available through mail-order include:

a. Antibiotics
b. Anti-anxiety
c. Anti-migraine
d. Injectables

e. Pain medications

f. Muscle relaxants

Prescriptions must be for a 90-day supply to be filled at Express Scripts' mail-order facility.

The mail-order facility may also contact Providers to see if they may substitute a brand name prescription with an equivalent generic medication when one is available.

Members should reserve the mail-order for those medications that are used for a chronic disease. To ensure that a medication will work for our Members, Express Scripts recommends that first time prescriptions be filled at a local pharmacy to ensure that there are no adverse effects of complications.

To use the mail-order program, Members should ensure that their medications is eligible for mail-order and all Preauthorization requirements have been met before sending in a prescription. Members should obtain a 90-day prescription from their physician, complete a mail order form and send the order along with payment to the address listed on the order form. Members should review their prescription for accuracy. Express Scripts' mail order facility is unable to fill prescriptions for 30-day supplies and may have to delay an order if they must verify the strength, dosage or directions with the prescribing physician.

Mail-order prescriptions may also be delayed if a duplicate prescription is filled at a local pharmacy with 10 days of requesting a mail-order prescription. Members should also avoid ordering a refill before 75% (68 days) of their prescription is gone. The mail-order facility will view the order as too early to fill. A Member should always have a 2-week supply of medication on hand to allow time for delivery. Members should also take into consideration that the mail-order facility is unable to supply medication of the manufacturer cannot supply the medication.

8.10.11 Generic Substitution Benefit

Members will be required to pay the difference between a generic medication and a brand name medication plus a generic Co-pay when the brand name medication is dispensed instead of a substitutable generic medication. If your benefit plan has a Deductible or Out-of-Pocket Maximum, the cost difference between a brand name medication and a generic equivalent does not apply to meeting your Deductible.

8.10.12 Initial Reviews for Benefit Claims: Non-Urgent Claims (Pre-Service and Post-Service)

If your plan requires you to obtain approval before a benefit will be payable, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below), and any other pre-service claims, you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim if Express Scripts has sufficient information to decide your claim. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

If Express Scripts does not have the necessary information needed to complete the review, Express Scripts will notify you to request the missing information within 15 days from receipt of your claim for pre-service and 30 days from receipt of your claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is considered denied and you have the right to appeal as described below.

Urgent Claims (Expedited Review)

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. If you receive an adverse determination on your claim, you will be provided with a written statement that explains the denial and includes instructions on how to appeal that decision.

An urgent care claim is defined as a request for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim is considered denied and you have the right to appeal as described below.

8.10.13 Appeals of Adverse Benefit Determinations Other Than Independent External Reviews

Non-Urgent Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit claim (including a claim considered denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of

receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription medication for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal

This information should be mailed to Express Scripts, PO Box 631850, Irving, TX 75063-0030 Attn: Appeals. A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription medication for which benefit coverage has been denied
- the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and
- any additional information that may be relevant to your appeal

This information should be mailed to Express Scripts, PO Box 631850, Irving, TX 75063-0030 Attn: Appeals. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service claims or 30 days of receipt of your written request for post-service claims. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e. your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e. any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you also have the right to bring a civil action under ERISA section 502(a) and/or to submit your claim for review by an external review organization. Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

Urgent Appeal (Expedited Review)

You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Urgent appeal requests may be oral or written. You or your physician may call 800-753-2851 or send a written request to:

Express Scripts
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determina-

tion within 72 hours of receipt of the claim. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal.

The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of Appeal prior to an external review. If your appeal is denied and you are not satisfied with the decision of the appeal (i.e. your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e. any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under ERISA, you also have the right to bring a civil action under ERISA section 502(a) and/or to submit your claim for review by an external review organization.

In addition, in urgent situations, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review. If you are not satisfied or you do not agree with the determination of the external review organization, you have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal your claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. External reviews are not available for decisions relating to eligibility.

8.10.14 Independent External Review Appeals of Adverse Benefit Determinations

External Appeals Review

You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, Express Scripts must receive your external review request within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: Express Scripts, Attn: External Review Requests P.O. Box 631850 Irving TX 75063-0030. Phone: 1 800 753 2851 Fax: 1 888 235 8551

Non-Urgent External Review

Once you have submitted your external review request, the Plan will review, within 5 business days, your claim to determine if you are eligible for external review, and within 1 business day of its decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

Urgent External Review

Once you have submitted your urgent external review request, the Plan will immediately determine if you are eligible for an urgent external review. Urgent processing will be granted if, in the judgment of the Plan, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. If you are eligible for urgent processing, the Plan will immediately determine if you are eligible for an external review and send you a letter notifying you whether your request for external review has been approved.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO. The IRO will notify you in writing that the request for an external review was received. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you

submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 72 hours and send you and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a).

8.11 DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFIT

See the Benefits Summary section for specific Co-pays.

For a complete list of services that require Preauthorization, please visit pehp.org or call 801-366-7555.

Purchase or rental of Durable Medical Equipment may be eligible if the criteria below are met.

Coverage is provided when the equipment is:

1. Medically Necessary;
2. Prescribed by a Provider and approved by PEHP; and
3. Used for medical purposes rather than for convenience or comfort.

PEHP will allow the cost of standard conventional equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies shall be the responsibility of the Member.

Except for oxygen and sleep equipment, if medical equipment will be required for longer than 60 days, it requires Preauthorization for review of continued rental verses purchase. The total benefits allowable for rental and/or subsequent purchase may not exceed 100% of the allowable purchase price of the equipment.

8.11.1 Limitations relating to Durable Medical Equipment/Supply Benefits

1. Machine purchase for the treatment of sleep disorders is payable at plan benefits, one machine in a five-year period. All related supplies are limited to $325 per plan year.
2. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
3. Two pair support hose per plan year for phlebitis or other eligible diagnosis.
4. One pair of ear plugs within 60 days following eligible ear Surgery.
5. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty.
6. Artificial prosthetics, such as limbs, when made necessary by loss from an injury, illness, or for congenitally missing limbs, must be Preauthorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Preauthorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.
7. Wheelchairs require Preauthorization through Mandatory Care Coordination and are limited to one power wheelchair in any five-year period.
8. Knee braces are limited to one custom and one off-the-shelf per knee in a three-year period.
9. Orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet are limited to $200 per plan year.
10. Hearing aids require Preauthorization. If approved, maximum of $1,500 every 5 years.
11. Oxygen Concentrators are allowed once in a 5-year period. PEHP will pay a monthly rental fee for a maximum of 36 months, regardless of the number of providers used. Contracted providers agree to 36 monthly rental payments as payment in full in a 5 year period.
12. Microprocessor or computer controlled braces and limbs.

8.11.2 Exclusions from Coverage relating to Durable Medical Equipment/Supply Benefit

The fact that a Provider may prescribe, order, recommend or approve a service or supply does not, of itself, make it a Covered Service, even though it is not specifically listed as an Exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition. For a complete list of non-Covered items, please visit pehp.org or call 801-366-7555.

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following Surgery for corneal transplant.
3. More than two pair of support hose for a medical diagnosis per plan year.
4. Durable Medical Equipment that is inappropriate for the patient's medical condition.
5. Diabetic supplies, i.e., insulin, syringes, needles, etc., are a pharmacy benefit.
6. TENS Unit.
7. Neuromuscular Stimulator.
8. H-wave Electronic Device.
9. Sympathetic Therapy Stimulator (STS).
10. Only conventional, body powered, cable-operated prosthetics or non-electronic conventional braces will be eligible for loss of a limb or congenitally missing limb(s). Additional charges for more elaborate or precision equipment will be the Member's responsibility.
11. Functional neuromuscular electrical stimulation devices.
12. Replacement of lost, stolen, or damaged equipment or supplies.
13. Intermittent limb compression devices at home

after surgery, unless the patient is unable to tolerate taking medication for preventing blood clots.

8.12 PREVENTIVE SERVICES

Under the Affordable Care Act, PEHP offers the following preventive services covered at no cost to you when received from an In-Network Provider. This list of preventive services is designed to comply with the Affordable Care Act. Notwithstanding this list of preventive services, PEHP reserves the right to modify these benefits at any time without notice, in accordance with federal law.

If these services are received from an Out-of-Network Provider they will be allowed up to the In-Network Rate and paid by PEHP at the In-Network Rate specified for Out-of-Network Providers by the Member's applicable Benefit Summary, if the Member's plan allows the use of Out-of-Network Providers. If the member's plan does not allow the use of Out-of-Network Providers, the services will be denied by PEHP.

We process 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, and preventive care is administered during the same visit, 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.

Also, it is important to note that the Department of Health and Human Services has defined the preventive services to be covered with no cost share as those services described in the U.S. Preventive Task Force A and B recommendations in accordance with federal law, therefore it is subject to change.

See applicable Benefits Summary for coverage information.

8.12.1 Covered Preventive Services for All Adults

- Preventive physical exam visits for adults, one time per plan year, which typically includes the following screenings:
  - Blood Pressure screening;
  - Alcohol Misuse screening and counseling;
  - Depression screening for adults;
  - 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;
  - 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.
- In addition to a preventive physical exam, the following preventive laboratory tests, procedures, and immunizations are also allowed once per plan year or as otherwise stated:
  - Basic/Comprehensive metabolic panel
  - Complete blood count
  - Urinalysis
  - Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked.
  - Cholesterol screening for adults of certain ages or at higher risk.
  - Colorectal Cancer screening for adults ages 45 to 75 (or prior to May 17, 2021, ages 50 to 75) using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Cologuard, once every three years. (If Cologuard test is positive, follow-up colonoscopy will be covered at regular benefits.)

    Note: *For Providers who bill for these services separately, General Anesthesia, or MAC, must be Medically Necessary and requires Preauthorization through PEHP.*
  - Falls prevention: older adults -- exercise intervention to prevent falls in community-dwelling adults 65 years or older who are at increased risk of falls.
  - Hepatitis C screening for all adults or persons at high risk.
  - HIV screening for adolescents, adults, and all pregnant persons.
  - Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
      - Males age 9-21 Gardasil
      - Females age 9-26 Gardasil or Cervarix
    - Influenza (Flu Shot)
    - Lung cancer screening
    - Measles, Mumps, Rubella
    - Meningococcal (Meningitis)
    - Pneumococcal (Pneumonia)
    - Shingles (Herpes Zoster)
      - Shingrix age 50 and above
      - Zostavax age 50 and above
    - Tetanus, Diphtheria, Pertussis (Td or Tdap)
    - Varicella (Chickenpox)
  - Type 2 Diabetes screening for adults with high blood

pressure.

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

» In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
  - › Aspirin use for men ages 45-79 and women ages 55-79.
  - › Aspirin, low-dose, for the primary prevention of cardiovascular disease (CVD) and colorectal cancer in adults age 50-59 years who have a 10% or greater 10-year CVD risk, and are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
  - › PrEP-Preexposure Prophylaxis for all persons at high risk of HIV
  - › Statin prevention medication for ages 40-75.
  - › Tobacco cessation interventions for tobacco users, up to the maximum approved dose and duration limits per plan year.

8.12.2 Covered Preventive Services specifically for women, including pregnant women

» In addition to the annual preventive physical exam for all adults listed in section 6.14.1 above, one well-woman exam is allowed per plan year to obtain recommended preventive services, which typically includes the following screenings:
  - › Domestic and interpersonal violence screening and counseling for all women;
  - › Tobacco Use screening for all women and expanded counseling for pregnant tobacco users;
  - › Sexually Transmitted Infections (STI) counseling for sexually active women.

Note: Additional preventive well woman exams in the plan year will be reviewed and must be recommended by the Provider.

» In addition to a preventive physical exam and/or well-woman exam, the following preventive laboratory tests, procedures, and devices are also allowed one time per plan year, per pregnancy, or as otherwise stated:
  - › Anemia screening on a routine basis for pregnant women.
  - › Bacteriuria urinary tract or other infection screening for pregnant women, as needed.
  - › Bone Density (DEXA) scanning for women age 60 and older.
  - › BRCA counseling about genetic testing for women at higher risk.
  - › BRCA testing for women at higher risk, requires Preauthorization from PEHP, one time per lifetime.
  - › Breast Cancer Chemoprevention counseling for women at higher risk.
  - › 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 Pre-Authorized by PEHP are also included.
  - › Cervical cancer screening (pap smear) every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
  - › Chlamydia Infection screening for younger women and other women at higher risk.
  - › Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient medications.
    - » Covered services/Devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphrams, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
  - › 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).
  - › Mammography screenings one time per plan year for women age 40 and above.
  - › Osteoporosis (bone density) screening for women over age 60 depending on risk factors.
  - › Preeclampsia screening for pregnant women with

blood pressure measurments throughout pregnancy.
  - Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
  - Syphilis screening for all pregnant women or other women at increased risk.
- In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
  - Breast Cancer chemoprevention medications for women at higher risk. Tamoxifen or Raloxifene.
  - Folic Acid supplements for women who may become pregnant.

8.12.3 Covered Preventive Services specifically for Children

- Preventive physical exam visits throughout childhood are allowed as recommended by the American Academy of Pediatrics which typically include the following screenings:
  - 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;
  - Depression screening for adolescents;
  - Height, Weight and Body Mass Index measurements for children;
  - Obesity screening and counseling;
  - Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
  - Vision acuity screening for all children one time between age 3 and 5.
- In addition to a preventive physical exam, the following preventive laboratory tests, procedures, and immunizations are allowed once per plan year or as otherwise stated:
  - Anemia.
  - Cervical dysplasia.
  - Congenital Hypothyroidism screening for newborns.
  - Critical congenital heart defect.
  - Developmental and behavioral screenings.
  - Dyslipidemia screening for children at higher risk of lipid disorders.
  - Fluoride varnish application for children done by a medical professional.
  - Gonorrhea preventive medication for the eyes of all newborns.
  - Hearing screening for all newborns, birth to 90 days old.
  - 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/.
  - Newborn Bilirubin.
  - Newborn blood.
  - Phenylketonuria (PKU) screening for this genetic disorder in newborns.
  - Skin cancer behavioral counseling -- young adults, adolescents, children, and parents of young children about minimizing exposure to UV radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
  - Tuberculin testing for children at higher risk of tuberculosis.
- In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
  - Fluoride Chemoprevention supplements for children without fluoride in their water source, when

obtained through the pharmacy.

› Iron supplements for children ages 6 to 12 months at risk for anemia.

8.12.4 Pilot Programs

PEHP, in conjunction with your employer, may participate in pilot programs for services to measure the effectiveness of such pilots prior to implementing broad changes to the Master Policy or payment contracts. For any pilot program, PEHP and your employer reserve the right to determine eligibility, benefits limits, member co-pays, length of time the pilot program will continue, all other aspects of the pilot program and any other condition for participation. If a pilot program is available to your employer, the specific information will be included in your benefits summary document.

IX. Catastrophic Sickness or Injury Benefits (Out-of-Pocket Expenses)

9 .1 CATASTROPHIC BENEFITS

See the Benefits Summary section for specific out-of-pocket limits.

Jordan School District has set limits for maximum out-of-pocket expense for Members. After the Member's share of eligible expenses exceeds specified amounts, PEHP will pay further Covered Services incurred during the remaining plan year at 100% of In-Network Rate.

9.1.1 Exclusions from Coverage relating to Maximum Out-of-Pocket Benefits

Amounts paid by the Member for the following services will not apply to the Member's out-of-pocket maximum:

1. Non-surgical treatment of Temporomandibular Joint (TMJ/TMD/Myofacial Pain);
2. Attended sleep studies, regardless of place of service, and unattended sleep studies performed in a facility whose payment is based on a percentage of the billed amount;
3. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
4. Charges in excess of the In-Network Rate or contract Limitations;
6. The cost difference between a brand name medication and a generic equivalent.

X. General Exclusions

10.1 SPECIFIC EXCLUSIONS

Specific Exclusions are listed under the most commonly applicable Benefit category, but are not necessarily limited to that category only.

10.2 GENERAL EXCLUSIONS FROM COVERAGE

1. Charges in excess of contract Limitations or AA.
2. All charges as a result of an Industrial Claim (on-the-job) injury or illness, regardless of whether the claim is determined compensable or settled with a worker's compensation carrier. Whether charges are the result of an Industrial Claim is solely determined by PEHP.
3. PEHP will only be liable for Covered Services for which the Member is liable. Payment will not be made, nor credit given toward Deductibles or out-of-pocket expenses for any expense for which the Member is not legally bound.
4. Charges for educational material or literature.
5. Charges for nutritional counseling except for the benefits provided for diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
6. Charges for scholastic education, vocational training, learning disabilities, or behavior modification.
7. Charges for medical care rendered by an Immediate Family Member.
8. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while a Member.
9. Provider's travel time.
10. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
11. Charges that are not medically necessary to treat the condition, as determined by PEHP, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury.
12. Charges for unproven medical practices or care, treatment, devices, or medications that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by PEHP.
13. Charges for services without adequate diagnosis or dates of service.
14. Charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which the individual is, or could be covered.
15. Charges for services as a result of an auto related injury and covered under No-fault insurance. If a Member fails to maintain No-fault insurance on his/ her own vehicle as required by law in the state they reside in, the minimum dollar amount they are required to maintain ($3,000 in Utah) for claims related to the auto injury are also excluded from Coverage.
16. Services, treatments, or supplies furnished by a Hospital or facility owned or operated by the United

States Government or any agency thereof while a member is on active duty.

17. Services, drugs, or supplies received which were caused by a Member's active participation as a result of an insurrection, terrorism, war or an act of war, whether declared or undeclared, or due to injur or illness incurred in the armed services of any country.
18. Any service or supply not specifically identified as a benefit.
19. Charges for commercial or private aviation services, meals, accommodations and car rental.
20. Charges for mileage reimbursement except for eligible ambulance service.
21. Charges by a Provider for case management
22. Charges for independent medical evaluations and/or testing for the purpose of legal defenses or disputes.
23. Charges for submission of Medical Records necessary for claims review.
24. Delivery, shipping, handling, sales tax, or finance charges.
25. PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Preauthorization, documented by Customer Service or Mandatory Care Coordination, or as described in this policy.
26. Complications as a result of any non-covered service, procedure, devices, or medication, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
27. Autopsy procedures.
28. Treatment of obesity by means of Surgery, medical services, or medication, regardless of associated medical, emotional, or psychological condition.
29. Unless an injury or illness was the result of a previous medical condition, services incurred in connection with injury or illness arising from the commission of
    a) a felony;
    b) an assault, riot or breach of peace;
    c) a Class A misdemeanor;
    d) any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e) other illegal acts of violence.
30. Claims submitted past the timely filing limit allowed per Section 5.1 of this Master Policy.
31. Charges for expenses in connection with appointments scheduled and not kept.
32. Charges for the treatment of sexual dysfunction.
33. Charges for services received as a result of medical tourism, or for traveling out of the United States to seek medical services or medications.
34. Medical services, procedures, supplies, devices, or medications used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies, devices, or medications are not covered. Such Complications include, but are not limited to:
    a. Complications relating to services, supplies, or devices for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar Surgical Procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct Complications or consequences thereof;
    b. Complications as a result of a Cosmetic Surgery or procedure, except in cases of Reconstructive Surgery:
        1. When the service is incidental to or follows a Surgery resulting from trauma, infection or other diseases of the involved party; or
        2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect;
    c. Complications relating to services, supplies, devices, or medications which have not yet been approved by the FDA or which are used for purposes other than its FDA-Approved purpose.
35. Pelvic or spinal manipulation under anesthesia.
36. Charges incurred while a Member is incarcerated or in police custody.
37. Services, procedures, medications, or devices received at or from a birthing center.
38. Functional neuromuscular electrical stimulation devices.
39. Overutilization of medical benefits as determined by PEHP.
40. Vitamins, oral or injected, and the associated administration, except for B-12 injections for selected diagnoses, as determined by PEHP.
41. Minerals, food supplements, homeopathic medicines, and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
42. Out-of-Network chiropractic services.
43. Trigger point injections done by an Out-of-Network Provider.
44. Court-ordered drug screening or confirmatory drug testing.
45. Surrogate pregnancy.
46. MTHFR testing.
47. Surgical or medical treatment of Peyronie's Disease.
48. All vitamins, oral or injected, and/or the associated administration, not listed as eligible elsewhere in this

Master Policy.

49. Micro-processor controlled braces.
50. Occipital nerve block for cervicogenic headache, occipital neuralgia, cluster headaches, chronic daily headache, and migraines.
51. Replacement of equipment, supplies, devices, Durable Medical Equipment, medications, or accessories that are lost, stolen or damaged.
52. Coverage is excluded for services outside the State of Utah when a member is traveling for the purpose of seeking medical care or treatment.
53. Frenulectomy of the mouth.
54. Hypoglossal Nerve Neurostimulation.
55. Fixation implants for Hammertoe surgery (other than K-wires, screws, or plates).
56. Metatarsal (toe or finger) phalangeal joint prosthetics, devices, modular implants, and biologic spacers (other than plates or screws).
57. Medical CPT or HCPC codes billed by a General Dentist unless as part of billing for a custom-molded sleep apnea oral device.
58. Whole exome and whole genome sequencing for the diagnosis of genetic disorders, unless preauthorized by PEHP at a children's undiagnosed clinic.
59. Genetic tests performed on tumors:
    a. Solid Tumor Mutation Panels/ Comprehensive Tumor Sequence Analysis;
    b. Myeloid Malignancies Mutation Panel (includes blood sample for hematologic tumors); or Genetic tests performed on blood sample ("Liquid" biopsy).
60. Chemical neurolysis for Morton's Neuroma and Plantar Fasciitis-add as direct exclusion.
61. Cryoneurolysis, including, but not limited to, the Iovera System.
62. Genicular nerve blocks.
63. Except for routine patient care costs, services, drugs or devices received as part of a clinical trial, including any services used to evaluate the performance of a Clinical Trial.
64. Ear-popping devices.
65. Endoscopic balloon dilation of the Eusatchian tube.
66. Intracept procedure.
67. Removal of excess skin on extremities, trunk, face or neck..
68. Rejuvenation of female genitalia.
69. PET for neurological disorders.
70. Pharmacogenetic tests for Major Depressive Order.
71. Charges that are a result of medical malpractice as reasonably determined by PEHP.
72. PEHP reserves the right to deny coverage for any new ICD-10 diagnosis codes, CPT or HCPC procedure codes, medications, supplies, or durable medical equipment until they have been thoroughly reviewed and approved for coverage by PEHP.
73. Radiofrequency neurolysis of the thoracic joints.

XI. Definitions

Accident, Dental
A single unpremeditated event of violent or external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from the act of biting or chewing are not considered within the definition of an Accident.

Accident, Medical
A single unpremeditated event of violent and external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from a willful action including lifting, pushing, pulling, bending, or straining are not considered within the definition of an Accident. Life-threatening conditions may not be considered within the meaning of an Accident.

Allowed Amount
The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "In-Network Rate." PEHP, in its discretion, may set an Allowed Amount at a lower rate than what is accepted by In-Network Providers when an Out-of-Network Provider is used.

Ambulatory Surgical Facility
Any licensed establishment with an organized medical staff of physicians, with permanent facilities equipped and operated primarily for the purpose of performing Ambulatory Surgical Procedures and with continuous physician services whenever a Member is in the facility but does not provide services or other accommodations for Members to stay overnight.

Community Standard
The standard accepted for consensus decisions will be determined by published medical data, in journals sponsored by professional societies and associations, patterns of care within PEHP database, professional review organizations, and consultations with experts who are Board Certified by the American Board of Medical Specialists. The Community Standard is not necessarily a prevailing level of practice.

Complication(s)
A medical condition, illness, or injury related to, or occurring as a result of another medical condition, illness, injury, Surgical Procedure, Device, or medication.

Conscious (Moderate) Sedation
An induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain patent airway, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.

Contracted Hospital
A Hospital with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee. Also referred to as In-Network Hospital.

Contracted Provider
A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee. Also referred to as In-Network Provider.

Coordination of Benefits
The Coordination of Covered Services between two or more plans under which an individual is covered after primary and secondary Coverage determination is made.

Copayment
The portion of the cost of Covered Services that a Member is obligated to pay under the plan(s), including Deductibles. A Copayment may be either a fixed dollar amount or a percentage of the allowable medical expense.

Cosmetic Procedure
Any procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.

Coverage
The eligibility of a Member for benefits provided under this Master Policy, subject to the terms, conditions, Limitations and Exclusions of this Master Policy.
Benefits must be provided:
1. When this Master Policy is in effect; and
2. Prior to the date that termination occurs.
3. Health care services and supplies as defined under PEHP's Master Policy(ies) that are eligible for reimbursement or Payment under a Plan.

Covered Services
Health care services and supplies as defined under PEHP's Master Policy(ies) that are eligible for reimbursement or Payment under a Plan

Creditable Coverage
Any comprehensive health insurance plan such as: a group health plan; health insurance Coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act; Chapter 55 of Title 10 of the United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the United States Code; a public health plan; or, a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e). Creditable Coverage does not include Excepted Benefits. (Excepted Benefits defined below).

Custodial Care
Services, supplies, or accommodations for care rendered which:
1. Do not provide treatment of injury or illness;
2. Could be provided by persons without professional skills or qualifications;
3. Are provided primarily to assist a Member in daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes; or
5. Maintain physical condition when there is no prospect of affecting remission or restoration of the Member to a condition in which care would not be required.

Deductible
The amount paid by a Member for eligible charges before any benefits will be paid under the plan.

Dependent
"Dependent" means:
1. The Subscriber's lawful spouse under Utah State Law. A valid marriage certificate and/or affidavit of marriage are required. A person to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under Utah State Law. In Utah, you must obtain a court order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court orders purporting to retroactively either establish or annul/declare void a marriage or divorce, PEHP will consider the change effective on the date the court order was signed by the court, or the date the order is received by PEHP, whichever is later.
2. Children or stepchildren of the Subscriber up to the age of 26 who have a Parental Relationship with the Subscriber. A valid birth certificate listing Subscriber or legal Spouse as parent is required.
3. Legally adopted children, who are adopted prior to turning 18 years old, foster children up to age 26, and children through legal guardianship up to the age of 26 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed.)
4. Children who are incapable of self support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber's federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber's Coverage continuing in effect. Periodic documentation is required. Subscriber must furnish written notification of the disability to PEHP no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning:
   a. The condition that led to the Dependent's physical or mental disability;
   b. Income, if any, earned by the Dependent; and
   c. The capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities.

   If proof of disability is approved, the Dependent's Coverage may be continued as long as he/she remains Totally Disabled and unable to earn a living, and as long as none of the other causes of termination occur.
   At the time of a Dependent's approval for continued PEHP Coverage, PEHP shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent's continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent's Coverage will terminate on the

renewal date.

5. When you or your lawful spouse are required by a court order to provide health Coverage for a child, the child will be enrolled in your Coverage according to PEHP guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions. The effective date for a qualified order will be the start date indicated in the order.
6. In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage but may be eligible to convert to a COBRA plan. PEHP will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree.
7. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under PEHP.
8. Dependent does not include an unborn fetus.

Device

Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for the purpose of:

1. Diagnosis, prevention, monitoring, treatment, or alleviation of illness or injury;
2. Diagnosis, monitoring, treatment, alleviation, or compensation for a handicap;
3. Investigation, replacement, or modification of the anatomy or of a physiological process, or;
4. Which does not achieve its principal intended action in or on the human body by pharmacological, immunological, or metabolic means, but which may be assisted in its function by such means.

Durable Medical Equipment

Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family Members for non-therapeutic purposes.

Elective Treatment

Non-emergency services that can be scheduled 48 hours after diagnosis.

Emergency

A medical condition of sudden or acute onset and symptoms of sufficient severity that a Member could reasonably expect the absence of immediate medical attention to result in the health of the Member in serious jeopardy, or would result in significant impairment to a bodily organ or function. PEHP shall determine whether a situation is an emergency based on the final diagnosis and review of the medical records.

Emergency Services

Medical services provided for an Emergency, including services received at an emergency department at a hospital and subsequent medical examination and treatment at a hospital until the Member is medically stabilized.

Employee

An Employer's Employee who is eligible for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

Employer

The State, its educational institutions and political subdivisions that are eligible to participate and have elected to participate in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

Enrollment

The process whereby an Employee makes written or online application for Coverage through PEHP, subject to specified time periods and plan provisions.

Excepted Benefits

Benefits not subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They are as follows: Coverage for Accident, or disability income insurance; Coverage issued as a supplement to liability insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; Coverage for on-site medical clinics; similar insurance Coverage under which benefits for medical care are secondary or incidental to other insurance benefits. The following benefits are not subject to requirements if offered separately: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination; other similar limited benefits. The following benefits are not subject to requirements if offered as independent non-coordinated benefits: Coverage only for a specified disease or illness; Hospital indemnity or other fixed indemnity insurance. The following benefits are not subject to requirements if offered as a separate insurance policy: Medicare supplemental Health insurance (as defined under section 1882(g)(1) of the Social Security Act), Coverage supplemental to the Coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental Coverage provided.

Exclusions

Those services or supplies incurred by the Member, which are not eligible under this policy.

Experimental, Investigational, or Unproven

Those services, supplies, Devices, or pharmaceutical (medication) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as solely determined by PEHP.

FDA Approved

Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

Formulary
A list of selected prescription medications reviewed by an independent Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an independent group of accomplished health care professionals comprised of physicians with various medical specialties and clinical pharmacists who assist in developing the Formulary. The P&T Committee reviews medications in all therapeutic categories relevant to the prescription medication benefit and evaluates them based on safety and efficacy. The Committee reviews new and existing medications on a regular basis and the Formulary is revised accordingly.

General Anesthesia
Anesthesia affecting the entire body and accompanied by a loss of consciousness.

Genetic Testing
The sequencing of DNA to discover the presence or absence of a mutation.

Global Fee
An amount negotiated for a specific procedure (such as an organ transplant) including multiple Providers, within a specified time frame.

Group Insurance Program
The program of Coverage created by Title 49, Chapter 20 of the Utah Code Annotated.

Holiday
Holiday is defined as any legal holiday of the State of Utah as defined in Utah Code Annotated § 63G-1-301(1).

Hospice Care
A program of supportive care that addresses the spiritual, social, and psychological needs of terminally ill patients and their families. The Global per diem benefit for Hospice includes: home care nursing, nursing aides, oral medication, Durable Medical Equipment, social worker, counseling, respite care, physical, occupational, and speech therapies provided for purposes of symptoms control or to enable the patient to maintain activities of daily living and basic functional skills.

Hospital
1. An institution which is licensed by the state in which it resides and maintains Medicare and Medicaid approval for services.
2. Any other institution which is operated pursuant to law, under the supervision of a staff of physicians and with twenty-four hour per day nursing service, which is primarily engaged in providing:
    a. General inpatient medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
    b. Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement or with a specialized Provider of those facilities.

In no event shall the term Hospital include a facility operated primarily as an outpatient or free standing unit, or a convalescent nursing home or an institution or part thereof which is used principally as a convalescent, rest, or nursing facility or facility for the aged, or which furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living, or which is operated primarily as a school. Hospitals are considered Providers in accordance with this Master Policy.

Immediate Family Member
Immediate Family Members are considered to be (for purposes of this policy): the Subscriber, the spouse, child, parent, brother, sister, domestic partner, or anyone that lives in the same home or for which one party is dependent on the other for financial support of any Subscriber or dependent covered under the Subscriber's plan. Immediate Family Member includes any step-relatives of the same types as are described above.

In-Network Contracted Provider
A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee.

In-Network Rate
The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "Allowed Amount." PEHP, in its discretion, may set an Allowed Amount at a lower rate than what is accepted by In-Network Providers when an Out-of-Network Provider is used.

Industrial Claim
Charges for an illness or injury arising out of or in the course of employment which charges are determined by PEHP to be covered by a Workers' Compensation carrier under the Utah Workers' Compensation Act.

Life-threatening
The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Member's life or cause permanent damage to the Member's health such as, but not limited to, loss of heartbeat, loss of consciousness, limb-threatening, or organ-threatening cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life-threatening event will be made by PEHP on the basis of the final diagnosis and medical review of the records. PEHP reserves the right to solely determine whether or not a situation is Life-threatening.

Lifetime Maximum Benefits or Lifetime Limits
Covered services that have a Lifetime Maximum Benefit apply to the Lifetime of the Member, and apply when a Member terminates and reinstates Coverage with the same Employer who offers Coverage through PEHP.

Limitations
Provisions in the plan indicating services or supplies that are not fully covered or covered only when specific criteria is met, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Medical Records
Medical reports, clinical information, and Hospital records relating to the care, treatment, and relevant medical history of the Member.

Medically Necessary/ Medical Necessity
Any healthcare services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a Member or Provider. However, such healthcare services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by PEHP. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not a "Covered Service" regardless of Medical Necessity.

Member
A Subscriber, a Subscriber's spouse, a Subscriber's Dependents who are enrolled in active Coverage or individuals who have converted to COBRA Coverage, Utah mini-COBRA Coverage, or a retired individual who is eligible for Coverage and has continued to pay contributions.

Mental Health
Mental Health Coverage shall include diagnosis codes as described in the International Classification of Disease code books, except where otherwise described or excluded in the policy.

Misuse or Abuse of Benefits or Failure to Cooperate
Includes, but is not limited to, a pattern of benefit misuse where a Member overutilizes benefits or uses benefits to obtain services beyond what is necessary to most appropriately treat the Member's condition. E.g., receiving multiple emergency room visits in a short period of time for conditions and services that could have been provided by a Provider at a lower level of care; or failure to reasonably cooperate and appropriately reimburse PEHP following an industrial injury or when there is a third party liable for claims.

Molecular Diagnostics
Analysis of biological markers regardless of source, to evaluate the genetic coding or expression of genes or proteins.

Monitored Anesthesia Care
Monitored Anesthesia Care (MAC) is the monitoring of a patient's physiological signs during a procedure in anticipation of the need for administration of general anesthesia or the development of adverse reactions to the procedure.

Package Fee
The cost benefit of "package" surgical services, which include the operation per se; local infiltration, metacarpal/digital block or topical anesthesia when used and normal, uncomplicated follow-up care. Normal, uncomplicated follow-up care would cover the period of Hospitalization and office follow-up for progress checks or any service directly related to the Surgical Procedure as per standard medical guidelines. The only exception would be if the service relates to Complications, exacerbations or recurrences of other diseases or injuries requiring additional or separate services. When an additional Surgical Procedure(s) is carried out within the listed period of follow-up care for a previous Surgery, the follow-up periods will continue concurrently to their normal termination.

Parental Relationship
The relationship between a natural child or stepchild and a parent while the child or stepchild is dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the Subscriber step-parent is terminated for any reason.

Payment
Amount paid by the Subscriber for the purchase of a medical benefits plan.

PBM
Pharmacy Benefit Manager.

Preauthorization
The process, prior to service, that the Member and the treating Provider must complete in order to obtain authorization for specified benefits of this Master Policy which may be subject to Limitations and to receive the maximum benefits of this Master Policy for Hospitalization, out-of-state, out-of-network, at a Rehabilitation, long-term acute care or Skilled Nursing Center, Hospitalization for Mental Health or Substance Abuse, Surgical Procedures, Durable Medical Equipment, pharmaceutical medication products, or other services as required. Preauthorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted. Preauthorization is valid only for the dates authorized, even if treatment has not been completed.

Primary Care Physician
A Provider acting within the scope of the Provider's practice limited to the following:

» Family Practice (FP)

» Internal Medicine (IM)

» Pediatrician (MD)

» Obstetrics and Gynecology (OBGYN)

» Gynecologist (GYN)

» Geriatrician (MD)

» Osteopath (DO)

and other Providers performing services for Members for the above Provider types including:

» Registered Nurse (RN)

» Advanced Practical Registered Nurse (APRN)

» Nurse Practitioner (NP)

» Certified Nurse Midwife (CNM)

» Physician's Assistant (PA)

Provider
A licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following: Medical Doctor (MD), Chiropractor (DC), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse Specialist (RN, NS), Doctor of Medical Dentistry (DMD), Dentist (limited) (DDS), Registered Nurse (RN), Advanced Practical Registered Nurse (APRN), Nurse Practitioner (NP), Physician Assistant (PA), Licensed Practical Nurse (LPN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Optometrist (limited [OD]), Audiologist, Licensed Professional Counselor (LPC), and Registered Dietician.

Reconstructive Surgery
Non-Cosmetic Surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Recreational Therapy
A treatment philosophy and format used for patients with mental or physical conditions or injuries to improve or maintain functionality, self confidence, socialization and a sense of well-being. Including, but not limited to, animal-assisted therapy.

Rehabilitation Therapy/Habilitation Therapy
The treatment of disease or injury by physical agents and methods to assist in the Rehabilitation and restoration of normal physical bodily function, that is goal oriented and where the Member has the potential for functional improvement and ability to progress.

Skilled Nursing Facility
An institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from illness or injury as an inpatient, and:

1. Has organized facilities for medical treatment and provides 24-hour nursing service under the full time supervision of a physician or a graduate registered nurse;
2. Maintains daily clinical records on each patient and has available the services of a physician under an established agreement;
3. Provides appropriate methods for dispensing and administering medications; and
4. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider. Any institution that is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism, is not considered a Skilled Nursing Facility.

Specialist
A Provider acting within the scope of the Provider's practice, limited to all other Provider types not defined as Primary Care Physicians.

Specialty Medication
Medications determined by PEHP and ExpressScripts to be payable only through the Specialty Medication Program based on one or more of the following:

1. Special administration requirements.
2. Special handling requirements.
3. Special clinical support requirements.
4. Product accessibility.
5. High cost of medication.
6. Availability of medication through PEHP's Specialty Medication vendor.
7. Other medications at PEHP's discretion.

Subrogation
PEHP's right to recover payments it has made on behalf of a covered Member because of an injury caused by a liable party.

Subscriber
An Employer's Employee who has enrolled for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

Surgical Procedure or Surgery
Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, treating pneumothorax, venipunctures, or endoscopy.

Totally Disabled
The complete inability, due to medically determinable physical or mental impairment, to engage in any gainful occupation.

Unbundling
The practice of using numerous procedure codes to identify procedures that normally are covered by a single code. (Also known as "fragmentation," "exploding," or "a la carte" medicine.)

Urgent Condition
An acute health condition with a sudden, unexpected onset, which is not Life-threatening but which poses a danger to the health of the Member if not attended by a physician within 24 hours; e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

Utah Prevailing Rate
The allowed amount PEHP would pay to the most relevant corresponding In-Network Provider as determined by PEHP.

Verbal Preauthorization
Prior approval obtained by calling PEHP in advance of treatment as required for some specific services and as documented by PEHP

Notice of Privacy Practices for Protected Health Information

effective January 7, 2020

Public Employees Health Program (PEHP) our business associates and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we have adopted the following privacy principles and information practices. PEHP is required by law to maintain the privacy of your protected health information, and to provide you with this notice which describes PEHP's legal duties and privacy practices. Our practices apply to current and former members.

It is the policy of PEHP to treat all member information with the utmost discretion and confidentiality, and to prohibit improper release in accordance with the confidentiality requirements of state and federal laws and regulations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Types of Personal Information PEHP collects

PEHP collects a variety of personal information to administer a member's health, coverage. Some of the information members provide on enrollment forms, surveys, and correspondence includes: address, Social Security number, and dependent information. PEHP also receives personal information (such as eligibility and claims information) through transactions with our affiliates, members, employers, other insurers, and health care providers. This information is retained after a member's coverage ends. PEHP limits the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

Disclosure of your protected health information within PEHP is on a need-to-know basis. All employees are required to sign a confidentiality agreement as a condition of employment, whereby they agree not to request, use, or disclose the protected health information of PEHP members unless necessary to perform their job.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy,
- Better understand who, what, when, where, and why others may access your health information,
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that

compiled it, the information belongs to you. You have the rights as outlined in Title 45 of the Code of Federal Regulations, Parts 160 & 164:

- Request a restriction on certain uses and disclosures of your information, though PEHP is not required to agree with your requested restriction.
- Obtain a paper copy of the notice of information practices upon request (although we have posted a copy on our web site, you have a right to a hard copy upon request.)
- Inspect and obtain a copy of your health record.
- Amend your health records.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.

PEHP must provide the accounting within 60 days of receipt of your written request.
The accounting must include:

- Date of each disclosure
- Name and address of the organization or person who received the protected health information
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

Examples of Uses and Disclosures of Protected Health Information

PEHP will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

Though PEHP does not provide direct treatment to individuals, we do use the health information described above for utilization and medical review purposes. These review procedures facilitate the payment and/or denial of payment of health care services you may have received. All payments or denial decisions are made in accordance with the individual plan provisions and limitations as described in the applicable PEHP Master Policies.

PEHP will use your health information for payment.
For example: A bill for health care services you received may be sent to you or PEHP. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

PEHP will use your health information for health operations.
For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. *Example: Your employer contracts with PEHP to provide a health plan, and PEHP provides your employer with certain statistics to explain the rates we charge.* For specific health information PEHP will only provide information after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

There are certain uses and disclosures of your health information which are required or permitted by Federal Regulations and do not require your consent or authorization. Examples include:

Public Health.
As required by law, PEHP may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Business Associates.
There are some services provided in our organization through contacts with business associates. When such services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Food and Drug Administration (FDA).
PEHP may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation.
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Correctional Institution.
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement.
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Our Responsibilities Under the Federal Privacy Standard

PEHP is required to:

- Maintain the privacy of your health information, as required by law, and to provide individuals

with notice of our legal duties and privacy practices with respect to protected health information
- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality
- Implement a policy to discipline those who violate PEHP's privacy, confidentiality policies.
- Mitigate (lessen the harm of) any breach of privacy, confidentiality.
- To notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should we change our Notice of Privacy Practices you will be notified.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law. PEHP is prohibited from using or disclosing the genetic information of an individual for underwriting purposes.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. Other uses and disclosures not described in this notice of privacy practices require your written authorization.

Inspecting Your Health Information

If you wish to inspect or obtain copies of your protected health information, please send your written request to PEHP, Customer Service, 560 East 200 South, Salt Lake City, UT 84102-2099 We will arrange a convenient time for you to visit our office for inspection. We will provide copies to you for a nominal fee. If your request for inspection or copying of your protected health information is denied, we will provide you with the specific reasons and an opportunity to appeal our decision.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the PEHP Customer Service Department at (801) 366-7555 or (800) 955-7347

If you believe your privacy rights have been violated, you can file a written complaint with our Chief Privacy Officer at:

ATTN: PEHP Chief Privacy Officer
560 East 200 South
Salt Lake City, UT 84102-2099.

Alternately, you may file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

CREDITABLE COVERAGE DISCLOSURE NOTICE

OMB 0938-0990

Important Notice from Jordan School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jordan School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Jordan School District has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th .

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Jordan School District coverage will not be affected. If you do join a Medicare drug plan and drop your current Jordan School District coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Jordan School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly

premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Jordan School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	May 1, 2022
Name of Entity/Sender:	Jordan School District
Contact--Position/Office:	District Insurance Office
Address:	7387 S Campus View Dr., West Jordan, UT 84084
Phone Number:	801-567-8146 or 801-567-8341

OMB 0938-0990

Jordan School District

Prescription Medication Program

With Participating Pharmacy Providers

The prescription medication program is separate from the medical plans outlined in this document.

Prescription Medication Program

Program Overview

The prescription medication program is separate from the medical plans outlined in this document.

CO-PAY AND CO-INSURANCE

Co-pays and co-insurances are listed in the Benefits Summary schedule. The "When Using an In-Network Provider" column in the schedule indicates the amount the Covered Person(s) must pay if they purchase prescriptions at a Participating Pharmacy.

COVERED MEDICATIONS

This program provides benefits for medications that require a prescription under state or federal law unless listed under "Prescription Medication and Mail Order Exclusions" (Section 8.10). This program reviews prescribing, dispensing, and consumption patterns for potential abuse. The system may also review claims for medication interactions, medication conflicts, duplicate therapies, over-utilization, and/or clinically appropriate maximum daily dose limits.

The 35% co-insurance on the Value Plan or 50% co-insurance on the Traditional Plan will be charged for a brand name drug that has a generic equivalent, regardless of who requests the brand name drug (e.g., Covered Person, physician, etc.).

There are a few generic medications that are not comparable to the associated brand name medications, as determined by the prescription claims administrator, therefore those medications will be dispensed at the following amounts: 20% co-insurance on the Value Plan or 35% co-insurance on the Traditional Plan.

This program covers the following diabetic supplies only if purchased at a Participating Pharmacy: insulin syringes, lancets, test strips, and alcohol swabs.

Methadone will only be available through a physician's office

HOW TO USE THE PRESCRIPTION CARD

1. *Use Participating Pharmacies.* A Participating Pharmacy is a pharmacy which has entered into a prescription medication plan agreement with Jordan School District or its administrator.
2. *Present the Jordan School District Insurance Identification card.*
3. *Pay the applicable co-pay at the time of purchase.* Covered Persons receive up to a 30-day supply (100 unit doses). Some maintenance medications may be available through the mail-order program. See "Mail Order Prescription Medication Plan" section below.
4. If the Covered Person has a prescription filled at a Non-participating Pharmacy, he will pay the pharmacy's full regular price. The Covered Person must then submit a direct reimbursement claim form to the prescription medication program manager. This program will reimburse the Covered Person for the amount the medication would have cost the program at a Participating Pharmacy less any applicable co-pay or co-insurance amount.

Mail Order Prescription Medication Plan

Covered Persons may be able to save money by purchasing their maintenance prescriptions through the mail order prescription medication plan.

The mail order prescription medication plan is separate from the medical plans outlined in this document. Co-insurance amounts for prescriptions apply toward the medical plan co-insurance maximum.

HOW TO USE THE MAIL SERVICE PROGRAM

1. New prescriptions: Ask the physician for a sample medication. If medication is required immediately, but will be taken on an on-going basis, ask the doctor to write two prescriptions: the first, up to a 30-day supply, to be filled at a retail pharmacy; the second, up to a 90-day supply (with up to three refills), to be filled through the mail order prescription medication plan. Send the second prescription along with the order form and the appropriate co-pay to the participating mail order prescription medication provider.
2. Prescriptions currently being taken: Obtain a new, written prescription from the physician. (In most cases, one can be obtained by calling the physician's office.) Send the new prescription along with the order form and the appropriate co-pay to the mail order prescription medication provider.
3. Important: Sign the order, indicating that the prescribed medications are for the Covered Person or covered family members. Unsigned orders will be returned unfilled.
4. The participating mail order prescription medication plan will process the order and return it via U.S. Mail or UPS, along with instructions for future refills. Allow up to 14 days for delivery from the time the Covered Person mails the prescription.
5. Refills: With the original prescription medication, the Covered Person will receive a notice showing the number of times it may be refilled. Simply mail this refill notice with the co-pay for each prescription in the order envelope provided. Refills should be ordered at least two weeks before they are needed.

Jordan School District

Flexible Spending Plan

Flexible Spending Plan

Plan Overview

Your employer, with the cooperation of PEHP, wants to help you increase your paychecks—to provide additional dollars to purchase needed fringe benefits.

This Plan can help you in three ways:

1. Reduce your tax obligations.
2. Provide new dollars to purchase needed benefits for you and your family.
3. Enable you to personally select what you need from the wide range of benefits made available by your employer.

Example of Plan Savings

This example illustrates $153.60 per month saved in taxes by using pre-tax dollars to pay your out-of-pocket expenses through your Flexible Spending Account; expenses you are now paying with after-tax dollars.

WITHOUT SECTION 125 FSA

Monthly Salary	$3,000.00
Taxes (30% Federal, State and FICA)	– 900.00
After-tax Medical Insurance	– 20.00
Take Home Pay	**$2,080.00**
Dependent Care Costs	– 400.00
Supplemental Group Term Life Premium	– 10.00
Out-of-pocket Health Care Costs	– 100.00
FSA Administration Costs	N/A
Spendable Income	**$1,570.00**

WITH SECTION 125 FSA

Monthly Salary	$3,000.00
Pre-tax Medical Insurance	– 20.00
Dependent Care Costs	– 400.00
Out-of-pocket Health Care Costs	– 100.00
Taxable Salary	**$2,480.00**
Taxes (30% Federal, State and FICA)	– 744.00
Supplemental Group Term Life Premium	– 10.00
FSA Administration Costs	– 2.75
Spendable Income	**$1,723.25**

General Information

ELIGIBILITY

If you are a regular full-time or a part-time employee eligible for benefits, you are eligible to participate in the Flexible Spending Account (FSA) program.

ADMINISTRATIVE CHARGE

An administrative charge will be assessed on a monthly basis and deducted September through August for those receiving 12 payroll checks throughout the plan year and September through June for those receiving 10 payroll checks throughout the plan year. The charge is determined annually between PEHP and Jordan School District. The fee is paid by the District if the annual election amount is at least $1,200.

IMPORTANT RESTRICTIONS

- You may begin participation during your open enrollment period only, unless you are a new hire.
- Funds may not be transferred from one account to another; the amount that you designate for medical reimbursement may not subsequently be used for reimbursement of dependent care expenses and vice versa.
- Funds remaining in your Reimbursable Care Accounts that are not used to reimburse eligible expenses incurred during the plan year, or during the two-and-one-half months ending on the 15th day of the third calendar month immediately following the plan year, may not be carried over to the next plan year, but must be forfeited to Jordan School District.
- Reimbursements made through the Flexible Spending Account may not be included as a deduction on your income tax return.
- The plan year goes from Sept. 1 through Aug. 31.
- As required by federal law, beginning Jan. 1, 2011, over-the-counter medication will no longer be eligible for reimbursement without a prescription from your provider.
- Effective Sept. 1, due to the "Affordable Care Act", participants may now be reimbursed for eligible medical expenses incurred by the participant on behalf of their child, who is under age 27 at the end of the taxable year. These expenses are eligible regardless of whether or not the child is the participants dependent for tax purposes or married. The expenses are not eligible if the child turns 27 years of age during the calendar year.

ELECTION CHANGES

- The Section 125 Plan allows an election change only in the event of a change in family status affecting your need for an elected benefit. A change in family status includes your marriage or divorce, the death of your spouse or child, or a change in your employment status and/or that of your spouse. Written notice of any change must be submitted to Jordan School District.
- If you terminate employment during the plan year and do not elect to continue participation in FSA under COBRA, you have 90 days to submit claims for eligible expenses incurred prior to the date of termination. You may not rejoin the Plan or continue making contributions on a pre-tax basis for the balance of the plan year.
- If you terminate employment during the plan year and you elect to continue your FSA under COBRA, you must complete a change-in-status form and state on the form that you are continuing under COBRA. This election is separate from a medical insurance COBRA election and can be made regardless of any medical insurance COBRA election. On the change-in-status form, you may elect to leave your commitment for the year the same or decrease it, but not below the amount already contributed. If there are sufficient funds in your final check, you may prepay the difference between your revised election and the amount previously contributed by having it withheld on that check (thus receiving the tax savings for that amount.) Or, you may elect to make payments for the difference in after-tax contributions. A 2% COBRA administration fee will be charged to all after-tax contributions. Regardless of the amount or payment method you elect, you may continue to incur expenses and submit claims. You will be reimbursed for eligible expenses incurred during the plan year, or during the two-and-one-half months ending on the 15th day of the third calendar month immediately following the plan year, up to the total amount you have contributed less all previous reimbursements.

Non-reimbursable Accounts

- Your Non-reimbursable Premium Only accounts do not require an annual enrollment in the Flexible Spending Account Program:
  a. Premium Only Accounts
  b. Group Medical Premiums
  c. Group Dental Premiums
  d. AFLAC Insurance Premiums
  e. Group Vision Insurance Premiums
- Your non-reimbursable insurance premium election is designed to give you a tax benefit on employer-sponsored insurance premiums not paid by Jordan School District, and for which you are liable.

Reimbursable Accounts

Reimbursable Accounts require annual enrollment in the Flexible Spending Account program; otherwise a deduction cannot be made:

- Health Care (Medical, Dental and Vision)
- Dependent Care (Child/Elderly)

HEALTH CARE ACCOUNT

Your Health Care Expense Reimbursement Account may be used to reimburse you for out-of-pocket expenses incurred for treatment of yourself, your spouse, and your eligible dependents. You may allocate up to $2,700 per plan year for a Health Care Account. A partial list of eligible and ineligible expenses follows.

Flexible Spending Reimbursement Guidelines—Allowable and Non-Allowable Benefits

The following are the flexible guidelines established by the Internal Revenue Service. Medical expenses include charges derived for the diagnosis, treatment, or prevention, or for treatment affecting any part or function of the body. They also include medicines and medications.

Benefits may be claimed for the Member and his dependents. For adopted children, you can include medical expenses that you paid for a child before adoption, if the child qualified as your dependent when the medical services were provided or when the expenses were paid.

Eligible Health Care Expenses

Eligible expenses are determined by the IRS include, but are not limited to, the following:

- Legal abortion.
- Acupuncture.
- Alcoholism. (Payments to a treatment center for alcoholics and medication addicts. This includes meals and lodging provided by the center during the medical treatment.)
- Ambulance.
- Artificial limb.
- Charges for an autoette or a manual or motorized wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and keeping up the autoette or wheelchair is also an allowable medical expense.
- Birth control pills by prescription.
- Braille books and magazines, to the extent and for the amount that the cost exceeds the regular price.
- Capital expenses. (Amounts you pay for special equipment installed in a home for improvements if the main reason is for medical care. Operation and upkeep also qualify as medical expenses, as long as the medical reason still exists.)
- Improvements made to a property rented by a disabled person. Amounts paid by a disabled person to buy and install special plumbing fixtures, mainly for medical reasons, in a rented house may qualify as medical expenses.
- Car—special equipment. The cost of special hand controls and other special equipment installed in a car for the use of a disabled person.
- Car—special design. The amount by which the cost of a car specially designed to hold a wheelchair is more than the cost of a regular car.
- Chiropractor.
- Christian Science Practitioners.
- Eyeglasses and contact lenses needed for medical reasons. You may include charges for eye examinations and contact lens solutions.
- Crutches.
- Dental treatment. (This includes fees paid to dentists, x-rays, fillings, braces, extractions, and dentures.)
- Doctors' fees. (This includes, but is not limited to, fees to chiropractors, ophthalmologists, osteopaths, podiatrists, psychiatrists, surgeons, pediatricians, dermatologists, anesthesiologists, gynecologists, obstetricians, and neurologists.)

- Psychiatric care. (This includes the cost of supporting a mentally ill dependent, as well as the cost of a specially equipped medical center where the dependent receives medical care.)
- Guide dog.
- Hearing aids.
- Hospital service.
- Laboratory fees that are part of medical treatment.
- Laetrile, prescribed by a doctor and purchased and used in a location where the sale and use are legal.
- Lead-based paint removal. (This includes the removal of lead-based paints from surfaces in a home to prevent a child who has or had lead poisoning from eating the paint. These surfaces must be in poor repair [peeling or cracking] or within the child's reach. The cost of repainting the scraped area is not a medical expense.)
- Tuition fees charged by a special school for a child who has severe learning disabilities caused by a mental or physical handicap, including nervous system disorders. A doctor must recommend that the child attend the school.
- Tutoring fees incurred on a doctor's recommendation for the child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities.
- Legal fees paid to authorize treatment for mental illness.
- Meals and lodging at a hospital or similar institution if the main reason for being there is to receive medical care.
- Lodging not provided in a hospital or similar institution while away from home if the following conditions apply:
    a. The lodging is primarily for and essential to medical care.
    b. Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to or the equivalent of a licensed hospital.
    c. The lodging is not lavish or extravagant under the circumstances.
    d. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.
    e. The amount you allow in medical expenses may not exceed $50 for each night for each person.
    f. Lodging is also allowable for a person not receiving the medical care, for example, a parent traveling with a sick child. In that case, up to $100 per night is allowable for lodging.
- Medicines and medications, or insulin.
- Special home for the mentally retarded on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living. (Not the home of a relative.)
- Mileage, reimbursable at $.19 per mile for verified travel to doctor and dentist appointment.
- Medical care, including meals and lodging for the Member, his spouse, or his dependents in a nursing home or home for the aged, if the main reason for being there is to get medical care.
- Wages and other amounts paid for nursing services, including amounts paid for an attendant's meals. Services need not be performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as the bathing and grooming of the patient.
- Charges for legal operations.
- Amounts charged for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition.
- Psychologist for medical care.
- Charges by a special school for a mentally or physically handicapped person if the main reason for using the school is that the school has resources for relieving the handicap. You may allow, for example, the cost of a school in which the following apply:
    a. Teaches Braille to a blind child.
    b. Teaches lip reading to a deaf child.
    c. Gives remedial language training to correct a condition caused by a birth defect.
- The cost of meals, lodging, and ordinary education supplied by a special school may be included in medical expenses only if the main reason for the child's being there is the resource the school has for relieving the mental or physical handicap.
- Charges for legal sterilization.
- Repair of special telephone equipment that lets a deaf person communicate over a regular telephone.
- Equipment that displays the audio part of television programs as subtitles for the deaf. This may be the cost of an adapter that attaches to a regular set. It also may be the excess cost of a specially equipped television over the cost of the same model regular television set.
- Charges for therapy received as medical treatment.

- Charges made by someone for giving patterning exercises to a mentally retarded child are allowable. These exercises consist mainly of coordinated physical manipulation of the child's arms and legs to imitate crawling and other normal movements.
- Charges for surgical, hospital, laboratory, and transportation expenses for a donor or a possible donor of a kidney or other transplant.
- Amounts charged for transportation primarily for and essential to medical care. You may include the following:
    a. Bus, taxi, train, or plane fare, or ambulance service.
    b. Actual car expenses, such as gas and oil. Do not include expenses for general repair, maintenance, depreciation, and insurance.
    c. Parking fees and tolls.
    d. Parent's transportation expense if a parent must go with a child who needs medical care.
    e. Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone.
    f. Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.
- X-ray Fees needed for medical reasons.

Ineligible Health Care Expenses

Ineligible expense include, but are not limited to, the following:

- Cost of operation of a specially equipped car, except as discussed above.
- Cosmetic surgery—for a face-lift or other cosmetic surgery.
- Dancing lessons, swimming lessons, etc., even if they are recommended by a doctor for the general improvement of one's health.
- Teeth bleaching/whitening or veneers.
- Charges for the removal of hair through electrolysis performed by a licensed technician.
- Cost of a surgical hair transplant performed by a physician.
- Charges for health club dues, YMCA dues, or steam baths for a person's general health or to relieve physical or mental discomfort not related to a particular medical condition.
- Household help, even if a doctor recommends it because a person is physically unable to do work.
- Life insurance.
- Policies for loss of life, limb, sight, etc.
- Policies that pay a guaranteed amount each week for a stated number of weeks a person is hospitalized for sickness or injury.
- The part of auto insurance premiums that provide medical insurance coverage for all persons injured in or by a car.
- Legal fees including guardianship or estate management fees.
- Meals and lodging while a person is away from home for medical treatment that is not received in a medical facility, or for the relief of a specific condition, even if the trip is made on the advice of a doctor.
- Meals and lodging if the reason for being in the home is personal or family-related.
- Charges by a plan that keeps a person's medical information by computer and that can give that information when needed.
- Special school for benefits the child may get from the course of study and the disciplinary methods.
- Transportation expenses to and from work, even if the condition requires an unusual means of transportation.
- Transportation expenses if, for nonmedical reasons only, a person chooses to travel to another city, such as a resort area, for an operation or other medical care prescribed by a doctor.
- Trips or vacations taken for a change in environment, improvement of morale, or general improvement of health, even if the trip is on the advice of a doctor.
- Weight-loss programs if the purpose of the weight control is to maintain general good health.
- Expenses submitted to any insurance carrier prior to, or simultaneously with, submission of those expenses to this Plan, until such time as the carrier denies such expenses.
- Expenses reimbursed by any other insurance policy, employer plan, or any other party, including a Health Maintenance Organization.
- Charges for any occupational illnesses or injury covered by Worker's Compensation.
- Health care insurance premiums not sponsored by your employer.
- Charges for services not recommended by a physician.
- Charges for services not Medically Necessary or not generally accepted as appropriate treatment according to the prevalent standards of medical care.
- Non-prescriptive expenses for appetite suppressants and/or weight control.
- Vitamins and food supplements.

- Charges for equipment not considered durable or medically necessary.
- Charges for capital improvements including swimming pools, elevators, air conditioners, and dust elimination systems not medically necessary.
- Elective cosmetic surgery.
- Charges for treatment or service rendered outside of the period eligible for the plan year.
- Toiletries and cosmetics.
- Non-prescription medications.

DEPENDENT CARE ACCOUNT

Expenses for dependent children are subject to requirements and limitations of Internal Revenue Code Section 125:

- Your dependent care expenses must be incurred to allow you and/or your spouse to work or to look for work.
- Your dependent must be less than 13 years old.
- You must have made payments for dependent care to someone you could not claim as a dependent and, if the person you make payments to was your child, he or she must have been age 19 or over by the end of the year.
- You may allocate up to $5,000 per tax year for reimbursement of dependent care expenses ($2,500 if you are married and file a separate tax return).

Dependent Eligibility

An eligible dependent is someone who falls into one of the following categories:

- Your dependent who is physically or mentally not able to care for himself or herself; or
- Your spouse who is physically or mentally not able to care for himself or herself.

Dependent Care Expenses

Eligible expenses include, but are not limited to, the following:

- Wages paid to a qualified dependent care provider for services inside or outside of your home.
- Employer taxes paid on the wages of a dependent care provider.
- Costs for a private school that provides care beyond educational requirements, but only for the portion that is not for the education.
- Costs for "away from home facilities" as long as your dependent spends at least eight hours a day at home.
- Services provided by a qualified day care center.
- Any other qualified dependent care expenses as defined by the Internal Revenue Code.
- Amounts paid to provide food, clothing, or education are not expenses paid for the care of a qualifying individual, unless these serviced are minimal or insignificant and inseparable from the portion of the expense that is for care. Where the manner of providing care is such that the expense which is incurred includes expenses for other benefits which are incident to and inseparably a part of the care, the full amount of the expense is considered to be incurred for care.

Health Care (medical, dental, vision) and Dependent Care (child/elderly) Account reimbursements MAY NOT ALSO BE CLAIMED AS A FEDERAL INCOME TAX CREDIT. Expenses exceeding the reimbursed amount may be claimed as an income tax credit.

CLAIMS

For Reimbursable Accounts

- All requests for reimbursement forms must be accompanied by a statement, bill, or insurance company explanation of benefits (EOB), showing date(s) of service and the amount you paid or the amount owing (less any future insurance payments).
- Claims for dependent care must be accompanied by an actual receipt signed by your dependent care provider and must include the provider's social security number and address.
- You will be reimbursed only for eligible expenses that you incur during the period allowed for the plan year, up to the date of termination.
- Under IRS guidelines, expenses are "incurred" when the patient is treated and not when the participant is formally billed, charged, or pays for the treatment. However, you may submit your claim for reimbursement as late as ninety (90) days after the end of the plan year for which the expenses were incurred.

BENEFIT CARDS – PEHP

All participants who enroll in a health spending account will receive a benefit card. The card is a MasterCard with certain restrictions and limitations. It can be used to pay copay amounts to doctors, dentists, pharmacies, and other medical providers for items covered by insurance. Documentation should be retained in the event that there is a question on the charge.

Copay amounts will be matched to charges on the card. If the amounts do not match, documentation will be requested by PEHP from the participant to clear the charges on the card. If the charges on the card are not cleared by data from the pharmacy, PEHP, or the participant, PEHP will request that the participant repay the amount(s) charged.

Reimbursements for non-prescription medications and other items purchased without using the card can be requested using a claim form available from www.pehp.org.

REIMBURSEMENT

For Reimbursable Accounts

If you do have secondary insurance coverage (COB) with or another carrier, you will be reimbursed after you submit a completed claim form accompanied by proper verification (statement, bill, receipt, etc.) of incurred expenses not covered by insurance.

Commonly Asked Questions

Answers to some of the most frequently asked questions about your Flexible Spending Account.

Q. ***How do I deposit money into my Flexible Spending Account?***

A. Determine what you want your monthly contribution to be and your employer will automatically deduct that amount from your paycheck over a 10- or 12-month period depending on how many checks are received during the year.

Q. ***How do I receive reimbursement from my Flexible Spending Account?***

A. Complete an FSA reimbursement claim form, attach receipts for your qualifying expenses and mail it to PEHP. Reimbursement checks or direct deposits will be issued to employees as promptly as possible.

Q. ***Is there a minimum amount of expenses that I must incur before submitting for reimbursement?***

A. No. However, PEHP requests that you wait until you have $25.00 or more in expenses to file a claim.

Q. ***If I don't use my account by the end of the plan year, may I carry it over to the next plan year and use it later?***

A. No. IRS guidelines do not permit this practice. Amounts you contribute to your Plan during the year that are not used for reimbursement of eligible expenses by the end of the plan year, or during the two-and-one-half months ending on the 15th day of the third calendar month immediately following the plan year, must be forfeited. The balance will revert to your employer.

Q. ***May I submit a claim for services that I received prior to the beginning of my current FSA plan year?***

A. No. Only expenses which have been incurred from the first day of your plan year through the last day of your plan year, or during the two-and-one-half months ending on the 15th day of the third calendar month immediately following the plan year, may be reimbursed. An expense is incurred when you receive the service, not when you are billed or pay for it.

Q. ***What if I incur my expenses during the plan year but submit them for reimbursement after the end of the plan year?***

A. Your account will be held open for three months following the end of the plan year. During that time you may continue to submit eligible expenses which were incurred during that plan year.

Q. ***May I change or cancel my elected contribution amount during the plan year?***

A. No. IRS guidelines do not permit you to change or terminate the amount of contribution to a Flexible Spending Account during the plan year, unless there is a change in family or employment status.

Q. ***Will I earn interest on the money held in my Flexible Spending Account?***

A. No. Interest will not be earned on contributions to these accounts. Since you are reimbursed regularly from your account, any interest earnings would be minimal.

Q. ***May I make additional lump sum contributions to my account?***

A. No. You may not make any contribution to your account other than the pre-elected payroll deducted monthly contribution.

Q. ***What if I terminate my employment during the plan year?***

A. If you terminate your employment during the plan year, you have 90 days to submit and be reimbursed for eligible expenses that were incurred up to your termination date.

Q. ***Will the amounts I contribute to Flexible Spending be included as income on my W-2 form?***

A. Amounts contributed to the Flexible Spending Account are not considered wages and thus, are not included as annual earnings on your W-2 form.

Q. ***Since I won't be paying Social Security taxes on a portion of my salary, how will this affect my future Social Security benefits?***

A. Considering the amount of salary which will not be taxed, the effects should be minimal.

Q. ***Could I use my contributions towards a dependent care account as a credit on my income tax?***

A. No. IRS guidelines do not allow this. It would be considered "double dipping" since you would be using the same expense twice to reduce your taxable income.

Q. ***What are examples of a change in family or employment status?***

A. Marriage, divorce, birth, adoption, death, termination of employment, or significant change in the number of hours worked.

Q. ***If I do have a family status change, how do I go about changing my contribution amounts?***

A. Any change in contribution due to change in family or employment status must be submitted in writing within 30 days after the change in status. A change-in-status form must be completed and submitted to your employer. Your employer will forward the changes with a copy of your written request to PEHP.

Q. ***Could I use my insurance premium and the expenses for which I received reimbursement under the Health Care account as a deduction on my income taxes?***

A. No. This is also considered "double dipping" since you would be using the same expense twice to reduce your taxable income.

Q. ***Am I better off taking a tax credit for dependent children care or using the Flexible Spending Dependent Care account?***

A. If your income exceeds $15,000, or you have a combined income of $18,000, you may be better off using the Flexible Spending Dependent Care account. If you have additional questions, consult your financial advisor for your specific situation.

Q. ***How much does my Flexible Spending Account Program cost me?***

A. An administration charge per month will be assessed. This is deducted 10 or 12 times, September through June or September through August depending on contract, and prorated per month.

Further questions may be directed to your PEHP representative by calling 801-366-7503 or 1-800-755-7703.