



**Member and Provider Services Department**  
**Josie Hall, Director**  
560 East 200 South, Salt Lake City, UT 84102  
801-366-7555 | 800-765-7347  
www.pehp.org

April 2024

Dear Member:

Open Enrollment is going on now and runs until May 31, 2024. This annual enrollment period is your only opportunity to make voluntary changes to your coverage until next year.

This packet contains an outline of your coverage and rates, important legal notices, and enrollment form. You can also access your benefit information when you login to your PEHP account at [www.pehp.org](http://www.pehp.org).

**Key points to remember:**

- » **If you're NOT making changes to your benefits, no action is required on your part.** You will be automatically re-enrolled in the same benefits.
- » Changes made during this enrollment period are effective July 1, 2024.
- » You and your covered dependents can enroll in benefit plans offered by your previous employer.
- » **To change plans**, complete the enclosed enrollment change form with all covered dependents and **return to PEHP by May 31, 2024.**

For faster processing, you can upload your completed form through the secure **Message Center** when you login to your PEHP account at [www.pehp.org](http://www.pehp.org). Simply snap a photo or scan your form.

Or mail the completed form to:

PEHP Enrollment  
560 East 200 South  
Salt Lake City, Utah 84102

- » You are responsible to pay the entire monthly rates shown in this packet.

If you have questions, please contact PEHP at 801-366-7555 or 1-800-765-7347.

Sincerely,

PEHP Enrollment



# Your To-Do Checklist

## 1 Medical Options

- STAR HSA Plan
- Traditional Plan
- Consumer Plus Plan

## 2 Network Options

- Summit
- Advantage

## 3 Dental Options

- Preferred
- Traditional
- EMI Choice Indemnity
- Basic HSA
- Discount HSA

» Claims or Other Questions? Contact a Health Benefits Advisor in your [Secure Message Center](#) or at 801-366-7555.

# Benefit Changes & Reminders

## STAR HSA Plan Changes

- » The deductible will increase to comply with minimum deductible limits under federal law for qualified high-deductible health plans.
- » The out-of-pocket maximum (OOPM) is changing to bring them in line with the Traditional Plan.
- » For double/family plans, there will be an individual OOPM cap of \$4,000, providing relief for a member facing high healthcare costs. This means that if one family member's out-of-pocket spending will be capped at \$4,000, rather than having to meet the entire family OOPM as in the previous plan year.

## Free Preventive Care Benefits

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider — even before you meet your deductible. Free services include colonoscopy, mammograms, annual physical exam, and vaccinations.

[See complete list of services and eligibility.](#)

## Mental Health Care & Services

If you or a loved one have a mental health crisis, you can get immediate help by calling the national crisis line at 988. You and your family have access to counseling services at no cost and for any reason through Blomquist Hale. Services are confidential, and they also offer a 24/7 crisis hotline. Call them at 1-800-926-9619. See other helpful [mental health care resources](#).

## Guaranteed Lowest Drug Price

When you fill a covered prescription, rest assured that you'll always get the best price when you visit the pharmacy. If savings are available via GoodRx, your prescription will automatically process with the lower cost, and we'll apply the lower paid amount to your deductible and out-of-pocket maximum. No need to show the pharmacist a GoodRx coupon.

# Important Links

- » [Enrollment Form](#)
- » [Summary of Benefits and Coverage – Traditional Plan](#)
- » [Summary of Benefits and Coverage – STAR HSA Plan](#)
- » [Summary of Benefits and Coverage – Consumer Plus Plan](#)
- » [Creditable Coverage Letter](#)
- » [Important Benefits Notices](#)
- » [Glossary of Health Coverage and Medical Terms](#)

State of Utah COBRA Rates			
Monthly Rates Effective July 1, 2024 - June 30, 2025			
Medical Plans	Single	Double	Family
Advantage STAR HSA	\$652.96	\$1,372.08	\$1,873.31
Advantage Traditional	\$810.61	\$1,669.39	\$2,225.54
Advantage Consumer Plus	\$567.32	\$1,179.99	\$1,678.22
Summit STAR HSA	\$633.62	\$1,331.38	\$1,817.64
Summit Traditional	\$786.60	\$1,619.90	\$2,159.46
Summit Consumer Plus	\$561.00	\$1,166.29	\$1,659.54
Dental Plans	Single	Double	Family
Preferred Dental	\$30.07	\$55.81	\$101.53
Traditional Dental	\$32.50	\$60.30	\$109.71
Basic HSA Dental	\$20.46	\$37.98	\$69.05
Discount HSA Dental	\$1.37	\$2.73	\$6.08
EMI Choice Indemnity Dental	\$42.73	\$75.39	\$133.63
Vision Plans	Single	Double	Family
Eyemed Full	\$7.61	\$12.26	\$16.88
Eyemed Eyewear Only	\$6.61	\$10.33	\$14.06

If you have any questions, please call customer service at (801) 366-7555  
or toll free at (800)765-7347.



**STAR HSA**

Summit & Advantage

**MEDICAL BENEFITS GRID: WHAT YOU PAY**

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$1,600 Double/family plans: \$3,200 <i>One person or a combination can meet the \$3,200 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b>	Single plans: \$3,000 Double plans: \$4,000 per person, \$6,000 per double Family plans: \$4,000 per person, \$9,000 per family <i>One person can only meet \$4,000, or a combination can meet the double/family maximum</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	20% after deductible	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Specialist Visits</b> <i>Includes inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	20% after deductible	20% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS   All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></b>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

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

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	<b>Tier A:</b> 40%. No maximum co-pay <b>Tier B:</b> 50%. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C1:</b> 10%. No maximum co-pay <b>Tier C2:</b> 20%. No maximum co-pay <b>Tier C3:</b> 30%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	20% after deductible	40% after deductible
<b>Emergency Room</b> <i>Emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% after deductible	20% after deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	20% after deductible	40% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Hospital Services</b> <i>Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>ART requires Preauthorization. Excludes multiple-embryo ART implants</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	20% after deductible	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires Preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Home Hospice</b>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	20% after deductible	40% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$1,000 lifetime maximum. See Master Policy for details</i>	20% after deductible	40% after deductible



**Traditional** (Non-HSA)

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

**In-Network Provider**

**Out-of-Network Provider\***

*Balance billing may apply*

<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Does not apply to Out-of-Pocket Maximum</i>	Single plans: \$350 Double/family plans: \$350 per person, \$700 per family <i>One person cannot meet more than \$350</i>	
<b>Plan year Out-of-Pocket Maximum</b> <i>Please refer to the Master Policy for exceptions to the out-of-pocket maximum.</i>	Single plans: \$3,000 Double plans: \$3,000 per person, \$6,000 per double Family plans: \$3,000 per person, \$9,000 per family <i>One person cannot meet more than \$3,000</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	Starting at \$10 co-pay per visit	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes inpatient visits and Autism services</i>	\$25 co-pay per visit <b>IHC:</b> \$35 co-pay per visit for Summit network <b>University of Utah Medical Group:</b> \$35 co-pay per visit	40% after deductible
<b>Specialist Visits</b> <i>Includes inpatient visits and Autism services</i>	\$35 co-pay per visit <b>IHC:</b> \$45 co-pay per visit for Summit network <b>University of Utah Medical Group:</b> \$45 co-pay per visit	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	\$35 co-pay per visit	\$35 co-pay per visit
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></b>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

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

State of Utah 2024-25 » Medical Benefits Grid » Traditional

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>SPECIALTY DRUGS   For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></b>		
<b>Specialty Medications, retail pharmacy</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. No maximum co-pay <b>Tier B:</b> 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20% after deductible. No maximum co-pay <b>Tier B:</b> 30% after deductible. No maximum co-pay	<b>Tier A:</b> 40% after deductible. No maximum co-pay <b>Tier B:</b> 50% after deductible. No maximum co-pay
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	<b>Tier A:</b> 20%. \$150 maximum co-pay <b>Tier B:</b> 30%. \$225 maximum co-pay <b>Tier C1:</b> 10%. No maximum co-pay <b>Tier C2:</b> 20%. No maximum co-pay <b>Tier C3:</b> 30%. No maximum co-pay	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	20% after deductible	40% after deductible
<b>Urgent Care Facility</b>	\$45 co-pay per visit	40% after deductible
<b>Emergency Room</b> <i>Emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	20% of In-Network Rate, minimum \$150 co-pay per visit	20% of In-Network Rate, minimum \$150 co-pay per visit
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	20% after deductible	
<b>Diagnostic Tests, Labs, X-rays – Minor</b> <i>For each test allowing \$350 or less, when the only services performed are diagnostic testing</i>	20% after deductible	40% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Physical and Occupational Therapy</b> <i>Outpatient – Up to 20 combined visits per plan year.</i>	Applicable co-pay per visit	40% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	40% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Hospital Services</b> <i>Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization</i>	20% after deductible	40% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption / Assisted Reproductive Technology (ART)</b> <i>ART requires Preauthorization. Excludes multiple-embryo ART implants</i>	20% after deductible, up to \$4,000 per adoption or up to \$4,000 per single-embryo ART implant	
<b>Allergy Serum</b>	20% after deductible	40% after deductible
<b>Chiropractic care</b>   <i>Up to 10 visits per plan year</i>	Applicable office co-pay per visit	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires Preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	20% after deductible	40% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 60 visits per plan year. Requires Preauthorization</i>	20% after deductible	40% after deductible
<b>Home Hospice</b>	20% after deductible	40% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	20% after deductible	40% after deductible
<b>Infertility Services</b>   <i>Select services only. See Master Policy for details.</i>	20% after deductible	40% after deductible
<b>Temporomandibular Joint Dysfunction</b> <i>Non-surgical. Up to \$1,000 lifetime maximum. See Master Policy for details</i>	20% after deductible	40% after deductible

# State of Utah 2024-25 » Consumer Plus » Benefits Grids

**Important Notice:** Consumer Plus is administered by its own Master Policy. The benefits are different from the Traditional or STAR plans. Find details in the Consumer Plus Master Policy.

**You may not select Consumer Plus unless you are currently on The STAR Plan.**

**If you choose Consumer Plus, you must enroll in an HSA-qualified plan the next enrollment period.**



## MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

**Percentages indicate your share of PEHP's In-Network Rate.**

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$3,000 Double/family plans: \$6,000 <i>One person or a combination can meet the \$6,000 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b>	Single plans: \$6,050 Double/family plans: \$12,100 <i>One person can only meet \$8,700, or a combination can meet the \$12,100 double/family maximum</i>	
<b>WELLCARE PROGRAM   ANNUAL ROUTINE CARE</b>		
<b>Affordable Care Act Preventive Services</b> <i>See Master Policy for complete list</i>	No charge	50% of In-Network Rate after deductible
<b>Vision Screening</b> <i>One time between ages 3 and 5</i>	No charge	50% of In-Network Rate after deductible
<b>Pediatric Dental Services**</b> <i>Routine cleaning, exams, x-rays and fluoride. Two times per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Sealants once every five years. See Master Policy for details.</i>	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
<b>Pediatric Vision Services</b> <i>Lenses only. One time per plan year. Age 3 through the end of the month in which the Member turns 19 years of age. Can see Provider of choice</i>	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	30% after deductible	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes inpatient visits and Autism services</i>	30% after deductible	50% after deductible
<b>Specialist Visits</b> <i>Includes inpatient visits and Autism services</i>	30% after deductible	50% after deductible
<b>Surgery and Anesthesia</b>	30% after deductible	50% after deductible
<b>Emergency Room Specialist Visits</b>	30% after deductible	30% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	30% after deductible	50% after deductible

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

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

\*\*Payable only as secondary to a dental plan or if member does not have a separate dental plan.

# State of Utah 2024-25 » Consumer Plus » Benefits Grids

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Preferred generic:</b> 30% of discounted cost <b>Preferred brand name:</b> 30% of discounted cost	Plan pays up to the discounted cost. Member pays any balance
<b>Specialty Medications, office/outpatient</b> <i>Up to 30-day supply</i>	30% of In-Network Rate. No maximum Co-Insurance	Not covered
<b>Specialty Medications, through Home Health or Accredo</b> <i>Up to 30-day supply</i>	30% of In-Network Rate. No maximum Co-Insurance	Not covered
<b>OUTPATIENT FACILITY SERVICES</b>		
<b>Outpatient Facility and Ambulatory Surgical Center</b>	30% after deductible	50% after deductible
<b>Urgent Care Facility</b>	30% after deductible	50% after deductible
<b>Emergency Room</b> <i>Emergencies only, as determined by PEHP. If admitted, inpatient facility benefit will be applied</i>	30% after deductible	30% after deductible
<b>Ambulance (ground or air)</b> <i>Medical emergencies only, as determined by PEHP</i>	30% after deductible	
<b>Diagnostic Tests, Labs, X-rays</b>	30% after deductible	50% after deductible
<b>Chemotherapy, Radiation, and Dialysis</b> <i>Dialysis from out-of-network provider requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Physical, Occupational and Speech Therapy</b> <i>Outpatient – Up to 10 combined visits per plan year.</i>	30% after deductible	50% after deductible
<b>Mental Health &amp; Substance Abuse</b>	30% after deductible	50% after deductible
<b>INPATIENT FACILITY SERVICES</b>		
<b>Hospital Services</b> <i>Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization</i>	30% after deductible	50% after deductible
<b>Skilled Nursing Facility and Residential Treatment</b> <i>Non-custodial. Up to 60 days per plan year. Requires preauthorization</i>	30% after deductible	50% after deductible

# State of Utah 2024-25 » Consumer Plus » Benefits Grids

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>MISCELLANEOUS SERVICES</b>		
<b>Adoption</b>	30% after deductible, up to \$4,000 per adoption	
<b>Allergy Serum</b>	30% after deductible	50% after deductible
<b>Chiropractic care</b>	Not covered	Not covered
<b>Durable Medical Equipment</b> <i>Some DME requires Preauthorization. Visit <a href="http://www.pehp.org">www.pehp.org</a> for complete list. See Master Policy for benefit limits</i>	30% after deductible Summit Network: Alpine Home Medical	50% after deductible
<b>Medical Supplies</b> <i>See Master Policy for benefit limits</i>	30% after deductible	50% after deductible
<b>Home Health/Skilled Nursing</b> <i>Up to 30 visits per plan year. Requires Preauthorization</i>	30% after deductible	50% after deductible
<b>Home Hospice</b>	30% after deductible	50% after deductible
<b>Injections</b> <i>Includes allergy injections. See above for allergy serum</i>	30% after deductible	50% after deductible
<b>Infertility Services</b>	Not covered	Not covered
<b>Sleep Studies and Sleep Equipment</b>	30% after deductible	50% after deductible
<b>Temporomandibular Joint Dysfunction</b>	Not covered	Not covered

# Medical Networks

## PEHP Advantage

37 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Intermountain Health providers and facilities.

<p><b>Beaver County</b> Beaver Valley Hospital Milford Valley Memorial Hospital</p> <p><b>Box Elder County</b> Bear River Valley Hospital</p> <p><b>Cache County</b> Logan Regional Hospital</p> <p><b>Carbon County</b> Castleview Hospital</p>	<p><b>Davis County</b> Davis Hospital Intermountain Layton Hospital</p> <p><b>Duchesne County</b> Uintah Basin Medical Center</p> <p><b>Garfield County</b> Garfield Memorial Hospital</p> <p><b>Grand County</b> Moab Regional Hospital</p> <p><b>Iron County</b> Cedar City Hospital</p>	<p><b>Juab County</b> Central Valley Medical Center</p> <p><b>Kane County</b> Kane County Hospital</p> <p><b>Millard County</b> Delta Community Hospital Fillmore Community Hospital</p> <p><b>Salt Lake County</b> Alta View Hospital Intermountain Medical Center The Orthopedic Specialty Hospital (TOSH) LDS Hospital</p>	<p><b>Salt Lake County (cont)</b> Primary Children's Medical Center Riverton Hospital</p> <p><b>San Juan County</b> Blue Mountain Hospital San Juan Hospital</p> <p><b>Sanpete County</b> Gunnison Valley Hospital Sanpete Valley Hospital</p> <p><b>Sevier County</b> Sevier Valley Hospital</p>	<p><b>Summit County</b> Park City Medical Center</p> <p><b>Tooele County</b> Mountain West Medical Center</p> <p><b>Uintah County</b> Ashley Valley Medical Center</p> <p><b>Utah County</b> American Fork Hospital Orem Community Hospital Primary Children's Hospital – Lehi Spanish Fork Hospital Utah Valley Hospital</p>	<p><b>Wasatch County</b> Heber Valley Medical Center</p> <p><b>Washington County</b> St. George Regional Hospital</p> <p><b>Weber County</b> McKay-Dee Hospital</p>
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## PEHP Summit

41 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly CommonSpirit (Holy Cross), MountainStar, and University of Utah hospitals & clinics providers and facilities.

<p><b>Beaver County</b> Beaver Valley Hospital Milford Valley Memorial Hospital</p> <p><b>Box Elder County</b> Bear River Valley Hospital Brigham City Community Hospital</p> <p><b>Cache County</b> Cache Valley Hospital</p> <p><b>Carbon County</b> Castleview Hospital</p>	<p><b>Davis County</b> Davis Hospital Lakeview Hospital</p> <p><b>Duchesne County</b> Uintah Basin Medical Center</p> <p><b>Garfield County</b> Garfield Memorial Hospital</p> <p><b>Grand County</b> Moab Regional Hospital</p> <p><b>Iron County</b> Cedar City Hospital</p>	<p><b>Juab County</b> Central Valley Medical Center</p> <p><b>Kane County</b> Kane County Hospital</p> <p><b>Millard County</b> Delta Community Hospital Fillmore Community Hospital</p> <p><b>Salt Lake County</b> Huntsman Cancer Hospital Jordan Valley Hospital Jordan Valley Hospital - West- Huntsman Cancer Hospital</p>	<p><b>Salt Lake County (cont)</b> Lone Peak Hospital Primary Children's Medical Center Riverton Children's Unit St. Marks Hospital University of Utah Hospital University Orthopaedic Center</p> <p><b>San Juan County</b> Blue Mountain Hospital San Juan Hospital</p> <p><b>Sanpete County</b> Gunnison Valley Hospital Sanpete Valley Hospital</p>	<p><b>Sevier County</b> Sevier Valley Hospital</p> <p><b>Summit County</b> Park City Medical Center</p> <p><b>Tooele County</b> Mountain West Medical Center</p> <p><b>Uintah County</b> Ashley Valley Medical Center</p>	<p><b>Utah County</b> Holy Cross Hospital – Mountain Point Mountain View Hospital Primary Children's Hospital – Lehi Timpanogos Regional Hospital</p> <p><b>Wasatch County</b> Heber Valley Medical Center</p> <p><b>Washington County</b> St. George Regional Hospital</p> <p><b>Weber County</b> Ogden Regional Medical Center</p>
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## Non-Covered Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit.

[See a list of Non-Covered Providers.](#)

## DID YOU KNOW?

In-network rates for services and facilities may be different between the two. Compare provider costs at [www.pehp.org/providerlookup](http://www.pehp.org/providerlookup)

# **Dental Plans**

## **Preferred**

*PEHP Dental network*

- » Small deductible that doesn't apply to preventive services
- » Pays 80% of in-network rate for X-rays and cleanings
- » Covers cleanings, preventive services, orthodontics, major services, etc.
- » \$1,500 annual limit per member, per plan year

## **Traditional**

*PEHP Dental network*

- » No deductible
- » Pays 100% of in-network rate for X-rays and cleanings
- » Covers cleanings, preventive services, orthodontics, major services, etc.
- » \$1,500 annual limit per member, per plan year

## **EMI Choice Indemnity**

*EMI Advantage Plus & Premier Networks*

- » Plan administered by EMI Health
- » No deductible
- » Pays 100% of in-network rate for X-rays and cleanings
- » Covers cleanings, preventive services, orthodontics, major services, etc.
- » \$1,500 or \$2,000 annual limit per member per plan year, depending on the EMI Network used (Advantage Plus or Premier)

## **IMPORTANT INFORMATION**

### **Waiting Period (PEHP Preferred and Traditional plans) »**

If you have been without dental coverage for more than 63 days, there is a waiting period of six months from the effective date of coverage for orthodontic, implant, and prosthodontic benefits. Waiting period may be waived with evidence of previous coverage. Learn more in the [Dental Master Policy](#).

**Missing Tooth Exclusion »** Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP. Learn more in the [Dental Master Policy](#).

» **MORE DENTAL OPTIONS** on next page

[See Dental Plan Costs](#)



# **Dental Plans** (continued)

## ***Basic HSA Dental***

- » Must be on STAR HSA or Consumer Plus medical plan
- » Small deductible that doesn't apply to preventive services
- » Pays 100% of in-network rate for X-rays and cleanings
- » Covers ONLY cleanings, preventive services, cavities
- » \$500 annual limit per member
- » If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Choice Indemnity for 3 years
- » Discounts available on non-covered services, except orthodontics

## ***Discount HSA Dental***

- » Must be on STAR HSA or Consumer Plus medical plan
- » If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Choice Indemnity for 3 years

[See Dental Plan Costs](#)



EFFECTIVE: JULY 1, 2024–JUNE 30, 2025  
OPEN ENROLLMENT: APRIL 15–MAY 31, 2024

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

	Preferred Dental Care		Traditional Dental Care	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>				
<b>Deductible</b> (Does not apply to diagnostic or preventive services)	\$25 per person, \$75 maximum per family	\$25 per person, \$75 maximum per family	\$0	\$0
<b>Annual Benefit Max</b>	\$1,500 per person	\$1,500 per person	\$1,500 per person	\$1,500 per person
<b>DIAGNOSTIC</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Periodic Oral Examinations</b>	\$0	20% of In-Network Rate	\$0	20% of In-Network Rate
<b>X-rays</b>	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
<b>PREVENTIVE</b>				
<b>Cleanings and Fluoride Solutions</b>	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
<b>Sealants</b>   Permanent molars only through age 17	20% of In-Network Rate	40% of In-Network Rate	\$0	20% of In-Network Rate
<b>RESTORATIVE</b>				
<b>Amalgam Restoration</b>	20% of In-Network Rate AD*	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Composite Restoration</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ENDODONTICS</b>				
<b>Pulpotomy</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Root Canal</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>PERIODONTICS</b>				
	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ORAL SURGERY</b>				
<b>Extractions</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>ANESTHESIA</b>   General Anesthesia in conjunction with oral surgery or impacted teeth only				
<b>General Anesthesia</b>	20% of In-Network Rate AD	40% of In-Network Rate AD	20% of In-Network Rate	40% of In-Network Rate
<b>Prosthodontic, implant, and orthodontic services below are not eligible for six months from the date coverage begins unless prior, continuous dental coverage can be shown</b>				
<b>PROSTHODONTIC BENEFITS</b>   Preauthorization may be required				
<b>Crowns</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Bridges</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Dentures (partial)</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>Dentures (full)</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>IMPLANTS</b>				
<b>All related services</b>	50% of In-Network Rate AD	70% of In-Network Rate AD	50% of In-Network Rate	70% of In-Network Rate
<b>ORTHODONTIC BENEFITS</b>   6-month Waiting Period				
<b>Maximum Lifetime Benefit per Member</b>	\$1,500 Does not apply to the Annual Benefit Maximum		\$1,500 Does not apply to the Annual Benefit Maximum	
<b>Eligible Appliances and Procedures</b>	50% of eligible fees to plan maximum AD		50% of eligible fees to plan maximum	

If you live outside of Utah and visit an out-of-state dentist, your benefits will be paid at the in-network rate. Note: You may be balance billed by the dentist for the full cost of your visit.

**Missing Tooth Exclusion** » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with a PEHP-sponsored dental plan. Learn more in the [Dental Master Policy](#). If coverage is provided by a PEHP medical plan, then there is no dental plan coverage.

\* AD = After Deductible

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

## Basic HSA Dental Care

*Must be on STAR HSA or Consumer Plus Plan*

	IN NETWORK	OUT OF NETWORK
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Deductible</b> Only applies restorative services	\$50 per person, \$150 maximum per family	\$50 per person, \$150 maximum per family
<b>Annual Benefit Max</b>	\$500 per person	\$500 per person
<b>DIAGNOSTIC</b>	<b>YOU PAY</b>	<b>YOU PAY</b>
<b>Periodic Oral Exams</b>	\$0	20% of In-Network Rate
<b>X-rays</b>	\$0	20% of In-Network Rate
<b>PREVENTIVE</b>		
<b>Cleanings and Fluoride Solutions</b>	\$0	20% of In-Network Rate
<b>Sealants</b>   Permanent molars only through age 17	\$0	20% of In-Network Rate
<b>RESTORATIVE</b>		
<b>Amalgam Restoration</b>	50% of In-Network Rate AD*	70% of In-Network Rate AD
<b>Composite Restoration</b>	50% of In-Network Rate AD	70% of In-Network Rate AD
<b>ENDODONTICS</b>		
Not covered, discount applies		
<b>PERIODONTICS</b>		
Not covered, discount applies		
<b>ORAL SURGERY</b>		
Not covered, discount applies		
<b>ANESTHESIA</b>		
General Anesthesia in conjunction with oral surgery or impacted teeth		
Not covered, discount applies		
<b>PROSTHODONTIC BENEFITS</b>		
Not covered, discount applies		
<b>IMPLANTS</b>		
Not covered, discount applies		
<b>ORTHODONTIC BENEFITS</b>		
Not covered		

\* AD = After Deductible

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Choice Indemnity for 3 years

## Discount HSA Dental Care

*Must be on STAR HSA or Consumer Plus Plan*

Discount HSA Dental offers no coverage for dental services, but you are eligible for an average savings of 40% on dental services when you visit dentists in the PEHP network (find them at [www.pehp.org](http://www.pehp.org) or by calling PEHP).

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Choice Indemnity for 3 years

[See HSA Contributions](#)

EFFECTIVE: JULY 1, 2024–JUNE 30, 2025  
OPEN ENROLLMENT: APRIL 15–MAY 31, 2024



## More Choices More Coverage



### State of Utah Employee 2024 Dental Plan Summary

Group: State of Utah  
Plan: #1580  
Choice Indemnity  
Effective Date: 07/01/24  
Benefit Year: Plan Year  
Benefit Type: Contributory/Fully Insured

Services	In-Network Advantage Plus	In-Network Premier	Out-of-Network
	<b>Preventive</b> Oral Exams, Cleanings, X-rays, Fluoride	100%	100%
<b>Basic</b> Fillings, Oral Surgery	80%	80%	80% up to R&C
<b>Major</b> Crowns, Bridges, Prosthodontics, Implants	50%	50%	50% up to R&C
<b>Orthodontics</b> , Dependent Children (7-18) Adults	50%	50%	50% up to R&C
<b>Endodontics</b>	Discount Only	Discount Only	No Coverage
<b>Periodontics</b>	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
<b>Sealants</b>	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
<b>Space Maintainers</b>	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
<b>Waiting Periods</b>	NONE		
<b>Deductibles</b>	NONE		
<b>Annual Maximum Per Person</b>	\$2,000	\$1,500	\$1,500
All maximums are combined to the limits above.			

<b>Orthodontic Lifetime Maximum</b>	\$1,500		
<b>Network Reimbursement Schedule</b>	Advantage Plus	Premier	R&C (80th)

When using a Non-participating Provider, the insured is responsible for all fees in excess of the reasonable and Customary Charges (R&C).

#### Provisions/Limitations/Exclusions

Exams (including Periodonal), Cleanings and Fluoride	2 per year
Fluoride	Up to age 16
Sealants	Up to age 16
Space Maintainers	Up to age 16
Bitewing X-Rays	Up to 4, twice per year
Periapical X-Rays	6 per year
Panoramic X-rays	1 every 3 years
Impacted Teeth	Covered in Type 2 - Basic
Anesthesia - (age 8 and over for the extraction of impacted teeth only)	Covered in Type 3 - Major
Anesthesia - (for children age 7 and under, once per year)	Covered in Type 3 - Major
Implants/Implant Abutments	Covered in Type 3 - Major
Crowns, Pontics, Abutments, Onlays, and Dentures	1 every 5 years per tooth
Fillings on the same surface	1 every 18 months



# Need Vision Coverage?

**Several Ways to Address Your Vision Needs** » You get vision exams through your medical plan and shop for frames and lenses using pre-tax dollars through an FSA, HSA or HRA. Or buy a vision plan to cover the bulk of vision costs. Do the math to see what's best for you. Here's a summary.

## With the STAR HSA Plan

Did you know that members on the STAR HSA Plan get one annual vision exam covered at 100% before deductible? If you're on The STAR HSA plan, take advantage of this great benefit to get a prescription from your in-network optometrist for lenses. Then shop around and use [HSA](#) dollars to pay for lenses and frames tax-free.

## With the Traditional Plan

A vision exam costs only a \$35 co-pay for an in-network optometrist. Once you get your prescription, shop for the best deal on frames and lenses.

## Funding Through EyeMed

You get your choice of two plans. One covers eyewear only while the other includes an eye exam. You may get a discount on frames from the sticker price.

[See Vision Plan Costs](#)



EFFECTIVE: JULY 1, 2024–JUNE 30, 2025  
OPEN ENROLLMENT: APRIL 15–MAY 31, 2024



## PEHP Full



**40% OFF**

additional complete pair of prescription eyeglasses

**20% OFF**

non-covered items, including non-prescription sunglasses

### Find an eye doctor (Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

### Heads up

You may have additional benefits. Log into [eyemed.com/member](https://eyemed.com/member) to see all plans included with your benefits.

### SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<b>EXAM SERVICES</b>		
Exam	\$10 copay	Up to \$30
Retinal Imaging	Up to \$39	Not covered
<b>CONTACT LENS FIT AND FOLLOW-UP</b>		
Fit and Follow-up – Standard	Up to \$40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up – Premium	10% off retail price	Not covered
<b>FRAME</b>		
Frame	\$0 copay; 20% off balance over \$100 allowance	Up to \$50
<b>STANDARD PLASTIC LENSES</b>		
Single Vision	\$10 copay	Up to \$25
Bifocal	\$10 copay	Up to \$40
Trifocal	\$10 copay	Up to \$55
Lenticular	\$10 copay	Up to \$55
Progressive – Standard	\$75 copay	Up to \$40
Progressive – Premium Tier 1 - 3	\$95 - 120 copay	Up to \$40
Progressive – Premium Tier 4	\$75 copay; 20% off retail price less \$120 allowance	Up to \$40
<b>LENS OPTIONS</b>		
Anti Reflective Coating – Standard	\$45	Not covered
Anti Reflective Coating – Premium Tier 1 - 2	\$57 - 68	Not covered
Anti Reflective Coating – Premium Tier 3	20% off retail price	Not covered
Photochromic – Non-Glass	\$75	Not covered
Polycarbonate – Standard	\$40	Not covered
Polycarbonate – Standard < 19 years of age	\$40	Not covered
Scratch Coating – Standard Plastic	\$15	Not covered
Tint – Solid or Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
<b>CONTACT LENSES</b>		
Contacts – Conventional	\$0 copay; 15% off balance over \$120 allowance	Up to \$96
Contacts – Disposable	\$0 copay; 100% of balance over \$120 allowance	Up to \$96
Contacts – Medically Necessary	\$0 copay; paid in full	Up to \$200
<b>OTHER</b>		
Hearing Care from Amplifon Network	Discounts on hearing exam and	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
<b>FREQUENCY</b>	<b>ALLOWED FREQUENCY - ADULTS</b>	<b>ALLOWED FREQUENCY - KIDS</b>
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months
(Plan allows member to receive either contacts and frame, or frames and lens services)		

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order, or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.



## PEHP Eyewear Only



**40% OFF**

additional complete pair of prescription eyeglasses

**20% OFF**

non-covered items, including non-prescription sunglasses

### Find an eye doctor (Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

### Heads up

You may have additional benefits.

Log into [eyemed.com/member](https://eyemed.com/member) to see all plans included with your benefits.

### SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<b>FRAME</b>		
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$65
<b>STANDARD PLASTIC LENSES</b>		
Single Vision	\$10 copay	Up to \$25
Bifocal	\$10 copay	Up to \$40
Trifocal	\$10 copay	Up to \$55
Lenticular	\$10 copay	Up to \$55
Progressive – Standard	\$75 copay	Up to \$40
Progressive – Premium Tier 1 - 3	\$95 - 120 copay	Up to \$40
Progressive – Premium Tier 4	\$75 copay; 20% off retail price less \$120 allowance	Up to \$40
<b>LENS OPTIONS</b>		
Anti Reflective Coating – Standard	\$45	Not covered
Anti Reflective Coating – Premium Tier 1 - 2	\$57 - 68	Not covered
Anti Reflective Coating – Premium Tier 3	20% off retail price	Not covered
Photochromic – Non-Glass	\$75	Not covered
Polycarbonate – Standard	\$40	Not covered
Polycarbonate – Standard < 19 years of age	\$40	Not covered
Scratch Coating – Standard Plastic	\$15	Not covered
Tint – Solid or Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
<b>CONTACT LENSES</b>		
Contacts – Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$104
Contacts – Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$104
Contacts – Medically Necessary	\$0 copay; paid in full	Up to \$200
<b>OTHER</b>		
Hearing Care from Amplifon Network	Discounts on hearing exam and	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
<b>FREQUENCY</b>	<b>ALLOWED FREQUENCY - ADULTS</b>	<b>ALLOWED FREQUENCY - KIDS</b>
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months
(Plan allows member to receive either contacts and frame, or frames and lens services)		

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

## Value Added Benefits

### Free Fast-Acting Insulin

You can get fast-acting insulin at no cost. Just ask your doctor to switch your prescription to Insulin Lispro (generic Humalog). Plus, you can get FreeStyle test strips with a \$10 copay and have access to a Continuous Glucose Monitor (CGM) to help you control your diabetes. These benefits are available to all members, including those on the STAR HSA plan and Consumer Plus plan before deductible.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/diabetes](http://www.pehp.org/diabetes)

### Legal Guardianship

This benefit allows children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. To continue coverage, the guardian child must have been enrolled in coverage prior to being 18 years of age and met the federal qualifications for coverage as a guardian child. Call PEHP to learn more, 801-366-7555 or 800-765-7347.

### PEHPplus

PEHPplus provides savings of up to 50 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/pehpplus](http://www.pehp.org/pehpplus)

### PEHP Value Providers

PEHP Value Providers include outstanding healthcare providers available to PEHP members with the lowest out-of-pocket costs. The next time you need care, don't forget these options for value and convenience.

#### FOR MORE INFORMATION

» Web: [www.pehp.org/valueproviders](http://www.pehp.org/valueproviders)

### Preventive Care

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider – even before you meet your deductible. If you're on the STAR HSA Plan, additional preventive visits and certain chronic medications are covered before you meet your deductible. See a list of medications on page 19 of the [Covered Drug List](#).

#### FOR MORE INFORMATION

» Web: [www.pehp.org/preventiveservices](http://www.pehp.org/preventiveservices)