PEHP Health & Benefits

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

May 2023

Dear Member:

PEHP is currently conducting open enrollment. This annual enrollment period is the only opportunity to make voluntary changes to your coverage until next year.

This packet contains an outline of your coverage and rates, legal notices, and enrollment form. Your benefit and claims information is also available within your PEHP account.

Please note:

- **If you are NOT making changes you don't need to do anything.**
- Plan and benefit changes are effective July 1, 2023.
- You and covered dependents can choose to enroll in all benefit plans offered by your prior employer.
- **To change plans,** complete the enclosed enrollment change form, listing all covered dependents, and **return to PEHP by May 26, 2023.**

  You can help us process your completed change form faster by **uploading it through the Message Center**. Simply snap a photo or scan your completed form, then go to www.pehp.org, click "Contact Us," then "Message Center."

  Or mail the completed form to:

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

- You are responsible to pay the full monthly rate unless applying unused Program I Sick Hours toward your medical coverage (see rates for how sick hours apply).

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

Sincerely,

PEHP Enrollment

PEHP Health & Benefits

State of Utah Early Retiree Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024
OPEN ENROLLMENT: APRIL 13–MAY 26, 2023

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 Dental
- [ ] Discount HSA Dental

» Claims or Other Questions? Contact a Health Benefits Advisor at 801-366-7555 or in your Secure Message Center

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

Benefit Changes & Reminders

Expanded Maternity Benefits

Starting July 1, coverage will be available for in-network doulas (birth coaches) and in-network birthing centers.

Mental Health Emergencies

If you have an emergency, you can get immediate help by calling the national crisis line at 988. You and your family can get 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. Learn more

Choose Your New Dental Option

You have several dental options, including a new option offered by EMI Health, which replaces Regence Expressions. See rates

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 Unused Sick Leave Benefit

State of Utah Early Retirement Rates with Sick Leave Hours*
Monthly Rates Effective July 1, 2023 - June 30, 2024

Early Retiree - **1st 18 months**				Early Retiree - **after 18 months**			
Medical Plans	**Retiree Share****	**State Share**	**Total**	Medical Plans	**Retiree Share****	**State Share**	**Total**
Traditional Plan - Advantage & Summit Network				**Traditional Plan - Advantage & Summit Network**			
Single	$59.84	$688.20	**$748.04**	Single	$76.27	$877.12	**$953.39**
Double	$123.39	$1,418.93	**$1,542.32**	Double	$157.26	$1,808.44	**$1,965.70**
Family	$164.72	$1,894.23	**$2,058.95**	Family	$209.93	$2,414.22	**$2,624.15**
STAR HSA Plan - Advantage & Summit Network				**STAR HSA Plan - Advantage & Summit Network**			
Single	$12.16	$595.65	**$607.81**	Single	$15.49	$759.18	**$774.67**
Double	$25.15	$1,232.20	**$1,257.35**	Double	$32.05	$1,570.46	**$1,602.51**
Family	$34.48	$1,689.40	**$1,723.88**	Family	$43.94	$2,153.16	**$2,197.10**
Consumer Plus - Advantage & Summit Network				**Consumer Plus - Advantage & Summit Network**			
Single	-	$517.87	**$517.87**	Single	-	$660.03	**$660.03**
Double	-	$1,077.28	**$1,077.28**	Double	-	$1,373.00	**$1,373.00**
Family	-	$1,542.30	**$1,542.30**	Family	-	$1,965.67	**$1,965.67**

DENTAL AND VISION - RETIREE PAYS THE TOTAL COST

Dental Plans	**Single**	**Double**	**Family**	**Dental Plans**	**Single**	**Double**	**Family**
Preferred Dental	$29.78	$55.28	$100.61	Preferred Dental	$35.04	$65.04	$118.37
Traditional Dental	$32.19	$59.73	$108.73	Traditional Dental	$37.87	$70.27	$127.92
Basic HSA Dental	$20.28	$37.64	$68.42	Basic HSA Dental	$23.86	$44.28	$80.50
Discount HSA Dental	$1.31	$2.43	$4.39	Discount HSA Dental	$1.54	$2.86	$5.16
EMI Choice Indemnity	$40.83	$71.92	$127.43	EMI Choice Indemnity	$47.61	$84.18	$149.49
Vision Plans	**Single**	**Double**	**Family**	**Vision Plans**	**Single**	**Double**	**Family**
EyeMed Full	$7.61	$12.26	$16.88	EyeMed Full	$7.61	$12.26	$16.88
EyeMed Eyewear Only	$6.61	$10.33	$14.06	EyeMed Eyewear Only	$6.61	$10.33	$14.06
OptiCare Full	$8.43	$12.62	$18.01	OptiCare Full	$8.43	$12.62	$18.01
OptiCare Eyewear Only	$6.53	$9.63	$13.03	OptiCare Eyewear Only	$6.53	$9.63	$13.03

*** Retirees are responsible for the "Total" monthly premium, unless using Program I Sick Hours for medical coverage.**

**** The Retiree Share is only applicable to those retiring with unused Program I Sick hours and applying them towards the Medical premium. Program 1 sick hours cover the "State Share."**

Main Menu

PEHP Health & Benefits

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.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,500 Double/family plans: $3,000 *One person or a combination can meet the $3,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $2,500 Double plans: $5,000 Family plans: $7,500 *One person or a combination can meet the $7,500 family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost. $25 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost. $50 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the 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* *Balance billing may apply*
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	20% after deductible	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***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*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

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

PEHP Health & Benefits

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*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Does not apply to Out-of-Pocket Maximum*	Single plans: $350 Double/family plans: $350 per person, $700 per family *One person cannot meet more than $350*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the out-of-pocket maximum.*	Single plans: $3,000 Double plans: $3,000 per person, $6,000 per double Family plans: $3,000 per person, $9,000 per family *One person cannot meet more than $3,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit **IHC:** $35 co-pay per visit for Summit network **University of Utah Medical Group:** $35 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit **IHC:** $45 co-pay per visit for Summit network **University of Utah Medical Group:** $45 co-pay per visit	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit	$35 co-pay per visit
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost. $25 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost. $50 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the 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* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	$45 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% of In-Network Rate, minimum $150 co-pay per visit	20% of In-Network Rate, minimum $150 co-pay per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***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*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

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

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.

PEHP Health & Benefits

Consumer Plus

(HSA-Qualified)
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*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $6,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $6,050 Double/family plans: $12,100 *One person can only meet $8,700, or a combination can meet the $12,100 double/family maximum*	
WELLCARE PROGRAM | ANNUAL ROUTINE CARE		
Affordable Care Act Preventive Services *See Master Policy for complete list*	No charge	50% of In-Network Rate after deductible
Vision Screening *One time between ages 3 and 5*	No charge	50% of In-Network Rate after deductible
Pediatric Dental Services** *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.*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
Pediatric Vision Services *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*	30% of In-Network Rate after deductible	50% of In-Network Rate after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	30% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	30% after deductible	50% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	30% after deductible	50% after deductible
Surgery and Anesthesia	30% after deductible	50% after deductible
Emergency Room Specialist Visits	30% after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays	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.

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

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

Medical Networks

DID YOU KNOW?

Advantage and Summit cost you the same. In-network rates for services and facilities may be different between the two. Compare provider costs at www.pehp.org/providerlookup

PEHP Advantage — 37 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

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

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)
LDS Hospital

Salt Lake County (cont)
Primary Children's Medical Center
Riverton Hospital

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
McKay-Dee Hospital

PEHP Summit — 42 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Steward Health, MountainStar, and University of Utah hospitals & clinics providers and facilities.

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

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Lakeview 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
Lone Peak Hospital

Salt Lake County (cont)
Primary Children's Medical Center
Riverton Children's Unit
St. Marks Hospital
Salt Lake Regional Medical Center
University of Utah Hospital
University Orthopaedic Center

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
Mountain View Hospital
Timpanogos Regional Hospital
Mountain Point Medical Center

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
Ogden Regional Medical Center

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.

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

- 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.
- Up to $2,000 annual limit per member, per plan year

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 (no orthodontics)
- $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

Discount HSA Dental

- Must be on STAR HSA or Consumer Plus medical plan
- Access to discounts, no insurance coverage
- If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Choice Indemnity for 3 years

» **MORE DENTAL OPTIONS** on previous page

See Dental Plan Costs

	Preferred Dental Care		Traditional Dental Care	
	IN NETWORK	**OUT OF NETWORK**	**IN NETWORK**	**OUT OF NETWORK**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS				
Deductible (Does not apply to diagnostic or preventive services)	**$25** per person, **$75** maximum per family	**$25** per person, **$75** maximum per family	**$0**	**$0**
Annual Benefit Max	**$1,500** per person	**$1,500** per person	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate	**$0**	**20%** of In-Network Rate
PREVENTIVE				
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate	**$0**	**20%** of In-Network Rate
RESTORATIVE				
Amalgam Restoration	**20%** of In-Network Rate AD*	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS				
Pulpotomy	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS				
	20% of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY				
Extractions	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only				
General Anesthesia	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate

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

PROSTHODONTIC BENEFITS | Preauthorization may be required				
Crowns	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS				
All related services	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS | 6-month Waiting Period				
Maximum Lifetime Benefit per Member	**$1,500** Does not apply to the Annual Benefit Maximum		**$1,500** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum AD		**50%** of eligible fees to plan maximum	

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

* **AD** = After Deductible	**IN NETWORK**	**OUT OF NETWORK**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible (Does not apply to diagnostic or preventive services)	**$50** per person, **$150** maximum per family	**$50** per person, **$150** maximum per family
Annual Benefit Max	**$500** per person	**$500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Exams	**$0**	**20%** of In-Network Rate
X-rays	**$0**	**20%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**$0**	**20%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**50%** of In-Network Rate AD*	**70%** of In-Network Rate AD
Composite Restoration	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
ENDODONTICS		
Not covered		
PERIODONTICS		
Not covered		
ORAL SURGERY		
Not covered		
ANESTHESIA General Anesthesia in conjunction with oral surgery or impacted teeth		
Not covered		
PROSTHODONTIC BENEFITS		
Not covered		
IMPLANTS		
Not covered		
ORTHODONTIC BENEFITS		
Not covered		

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or EMI Health 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 25% on dental services when you visit dentists in the PEHP network (find them at 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

EMI HEALTH

More Choices More Coverage

State of Utah Employee Dental Plan Summary

Group: State of Utah
Plan: #1580
Choice Indemnity
Effective Date: 07/01/23
Benefit Year: Plan Year
Benefit Type: Contributory/Fully Insured

Services	In-Network Advantage Plus	In-Network Premier	Out-of-Network
Preventive Oral Exams, Cleanings, Sealants, X-rays, Fluoride	100%	100%	100% up to R&C
Basic Fillings, Space Maintainers, Oral Surgery	80%	80%	80% up to R&C
Major Crowns, Bridges, Prosthodontics, Implants	50%	50%	50% up to R&C
Orthodontics, Dependent Children (7-18)	50%	50%	50% up to R&C
Adults	25% discount	25% discount	no coverage
Endodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Sealants	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Space Maintainers	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Waiting Periods	NONE		
Deductibles	NONE		
Annual Maximum Per Person	$2,000	$1,500	$1,500
	All maximums are combined to the limits above.		

Orthodontic Lifetime Maximum	$1,500		
Network Reimbursement Schedule	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

(800) 662-5851 | emihealth.com
5101 S. Commerce Drive, Murray, UT 84017

Underwritten and Administered by Educators Health Plans Life, Accident & Health
(EMI.MKTG.STATEOFUTAHDENTAL.0323.1238)

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 $35 co-pay for an in-network optometrist. Once you get your prescription, shop for the best deal on frames and lenses. Use FLEX$ money to pay for the eyewear with pre-tax dollars.

Funding Through Opticare

Opticare Vision Services is a Utah owned vision benefits company offering State of Utah employees their choice of two plan options. Opticare uniquely offers flexibility to access three network options at the time of service. Members have their choice of using the Select Network (including Standard Optical locations with richest benefits), the Broad Network containing vision store chains and private practice providers, and Out of Network benefits to providers such as Costco and Walmart.

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

OpticareVision services

OPTICARE PLAN – PEHP – Eye Exam & Hardware Benefits

0-10-150/140C

Products/Services	Select Network	Broad Network	Out-Of-Network
Eye Exam			
Eyeglass exam	100% Covered	$10 Co-pay	$40 Allowance
Retinal Imaging	$20 Co-pay	$39 Co-pay	Included above
Standard Contact Fit & Follow Up Fee	100% Covered	$40 Co-pay	Included above
Specialty Contact Fit & Follow up Fee (Toric or Multifocal)	$40 Co-pay	$80 Co-pay	Included above
Standard Plastic Lenses			
Single Vision	100% Covered	$10 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$10 Co-pay	
Trifocal (FT 7x28)	100% Covered	$10 Co-pay	
Lens Options			
Progressive (Standard plastic no-line)	$30 Co-pay	$50 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Premium Progressive Options	$80 Co-pay	$100 Co-pay	
Polycarbonate Kids (Under age 19)	$20 Co-pay	$40 Co-pay	
Polycarbonate Adults	$40 Co-pay	$40 Co-pay	
Transitions / Photochromic	$50 Co-pay	$75 Co-pay	
Coatings			
Scratch Resistant Coating	$10 Co-pay	$15 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Ultraviolet protection	$10 Co-pay	$15 Co-pay	
Tint	100% Covered	$10 Co-pay	
Premium Anti-Reflective	$50 Co-pay	25% Discount	
Specialty Anti-Reflective	25% Discount	up to 25% Discount	
Polarized	25% Discount	up to 25% Discount	
Other Options: Edge polish, tints, mirrors, etc.	Up to 25% Discount	Up to 25% Discount	
Frames			
Allowance Based on Retail Pricing	$150 Allowance	$130 Allowance	$70 Allowance
Additional Eyewear			
Additional Prescription Glasses	Up to 50% Off Retail	Up to 25% Off Retail	Not Covered
Non-Rx (Plano Sunglasses)	25% Discount	20% Discount	Not Covered
Contacts			
Contact benefits is in lieu of Eyeglasses	$140 Allowance	$130 Allowance	$100 Allowance
Additional contact purchases:	Up to 20% off Retail	Up to 10% off Retail	Not Covered
Medically Necessary Contacts	100% Covered	$250 Allowance	$200 Allowance
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Refractive Surgery			
LASIK	20% Off Retail	Not Covered	Not Covered
Dry Eye Treatments			
Punctal Occlusion	$250 / Puncta Silicone	Not Covered	Not Covered
Punctal Occlusion Nutraceuticals	$75 / Puncta Collagen	Not Covered	Not Covered
Macu Health & Blink Dry Eye Formulas	10% Discount	Not Covered	Not Covered

OpticareVision services

OPTICARE PLAN – PEHP
Hardware Only (no eye exam benefit)
10-150/140C

Products/Services	Select Network	Broad Network	Out-Of-Network
Standard Plastic Lenses			
Single Vision	100% Covered	$10 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$10 Co-pay	
Trifocal (FT 7x28)	100% Covered	$10 Co-pay	
Lens Options			
Progressive (Standard plastic no-line)	$30 Co-pay	$50 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Premium Progressive Options	$80 Co-pay	$100 Co-pay	
Polycarbonate Kids (Under age 19)	$20 Co-pay	$40 Co-pay	
Polycarbonate Adults	$40 Co-pay	$40 Co-pay	
Transitions / Photochromic	$50 Co-pay	$75 Co-pay	
Coatings			
Scratch Resistant Coating	$10 Co-pay	$15 Co-pay	$65 Combined allowance for all lenses, options, and coatings
Ultraviolet protection	$10 Co-pay	$15 Co-pay	
Tint	100% Covered	$10 Co-pay	
Premium Anti-Reflective	$50 Co-pay	25% Discount	
Specialty Anti-Reflective	25% Discount	up to 25% Discount	
Polarized	25% Discount	up to 25% Discount	
Other Options: Edge polish, tints, mirrors, etc.	Up to 25% Discount	Up to 25% Discount	
Frames			
Allowance Based on Retail Pricing	$150 Allowance	$130 Allowance	$70 Allowance
Additional Eyewear			
Additional Prescription Glasses	Up to 50% Off Retail	Up to 25% Off Retail	Not Covered
Non-Rx (Plano Sunglasses)	25% Discount	20% Discount	Not Covered
Contacts			
Contact benefits is in lieu of Eyeglasses	$140 Allowance	$130 Allowance	$100 Allowance
Additional contact purchases:	Up to 20% off Retail	Up to 10% off Retail	Not Covered
Medically Necessary Contacts	100% Covered	$250 Allowance	$200 Allowance
Frequency			
Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Refractive Surgery			
LASIK	20% Off Retail	Not Covered	Not Covered
Dry Eye Treatments			
Punctal Occlusion	$250 / Puncta Silicone	Not Covered	Not Covered
Punctal Occlusion Nutraceuticals	$75 / Puncta Collagen	Not Covered	Not Covered
Macu Health & Blink Dry Eye Formulas	10% Discount	Not Covered	Not Covered

EyeMed

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** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $30
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
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
FRAME		
Frame	$0 copay; 20% off balance over $100 allowance	Up to $50
STANDARD PLASTIC LENSES		
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
LENS OPTIONS		
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
CONTACT LENSES		
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
OTHER		
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

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
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.

EyeMed

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** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
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
LENS OPTIONS		
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
CONTACT LENSES		
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
OTHER		
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

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
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)

Value Added Benefits

Diabetes Savings Program

You may qualify for less expensive test strips and short-acting insulin if you enroll in the Diabetes Savings Program.

FOR MORE INFORMATION

» **Web:** 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, so check it out at 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

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. See your preventive care checklist at www.pehp.org/preventiveservices

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.

PEHP Health & Benefits

State of Utah Early Retiree

Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024

OPEN ENROLLMENT: APRIL 13–MAY 26, 2023

PEHP Cost Tools

Shop for the best care and the best value using PEHP's Cost Tools.

You may even find cash back.

Learn more: www.pehp.org/save

PEHP Health & Benefits