PEHP Health & Benefits

Utah Housing Corporation Benefits Guide

EFFECTIVE: JULY 1, 2022–JUNE 30, 2023
OPEN ENROLLMENT: APRIL 18–MAY 18, 2022

Your To-Do Checklist

1 Medical Options

- [ ] STAR HSA Plan
- [ ] Traditional Plan
- [ ] Opt-Out Cash Benefit

2 Network Options

- [ ] Summit
- [ ] Advantage

3 Dental Options

- [ ] Preferred
- [ ] Traditional
- [ ] Regence Expressions
- [ ] Opt-Out Cash Benefit

If you're happy with your current benefits, you don't need to do anything, except re-enroll in FLEX$ if you have a FLEX$ account. If you have other qualifying medical and/or dental coverage, you can enroll in the Opt-Out Cash Benefit.

Navigating This Guide

Click the icons below for detailed information about each topic

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PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

Benefit Changes & Reminders

Preferred Network No Longer Available

Effective July 1, 2022 the Preferred Network will no longer be available by your employer. This means you may only elect the Advantage or Summit Network. See hospital list on page 16.

Assisted Reproductive Technology

A $4,000 benefit is available each time In Vitro Fertilization Services are used to implant a single embryo.

Other Insurance Coverage?

If you have other qualifying medical or dental coverage, you can sign up for the Opt-out Cash Benefit during open enrollment and get cash added to your salary. ***Opt-out of coverage through your Medical and Dental online enrollment.***

PEHP Cost Tools

Use PEHP Cost Tools to keep more money in your pocket and find cash back. Learn more at www.pehp.org/save.

Life Event During Open Enrollment

If you have a life event, such as a child/adoption, marriage/divorce, or lose other insurance coverage during Open Enrollment, make sure to add/drop coverage using the "Midyear Event" section of online enrollment to ensure coverage begins or ends the correct date.

Life Assistance Counseling

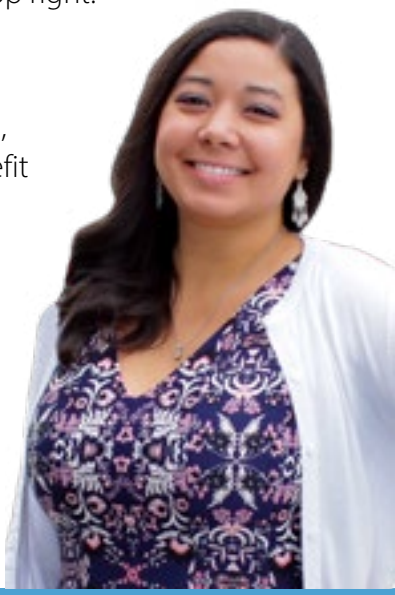
You have access to ***free*** life assistance counseling through Blomquist Hale. Learn more at www.blomquisthale.com

Do We Have Your Current Contact Information?

It's important that we have your correct address to ensure claims are processed correctly and you receive cash back, if applicable. Log in to your PEHP account and click on "Update Contact Information" under your account on the top right.

Still Eligible for HSA?

If your eligibility has changed, please be aware of your benefit options.



» *PEHP specialist Taylor Hooton*

Things to Consider
before choosing medical plan

1 How often do you use your medical plan?

- If you only have routine or office visits, switching to a lower-cost plan and paying the full cost of office visits may be more cost-effective. What's more important: lower upfront costs (Traditional Plan) or more take home pay (STAR HSA plan)?
- Chronic conditions, prescriptions, specialists, etc. How much did you spend on these things last year? The year before?
- Anything on the horizon - having a child, upcoming surgery or service?

Did you know?

You can download your claims history from your PEHP account to see how much you spend on healthcare in an average year.

2 How much will covered healthcare cost you?

Annual premium - see page 4 for plan amounts

- Remember, this is deducted from your paycheck whether you go to the doctor or not.

Deductible & Out-of-Pocket Maximum (OOPM)

- Traditional Plan: copays go towards your OOPM, but not your deductible. Your total out of pocket costs would be the deductible + OOPM. Remember, each person has their own individual deductible & OOPM until the double/family limits are met.
- STAR HSA: The OOPM is the most you will pay in a year for covered in-network services. Your OOPM includes what you've paid in your deductible.

3 What about a Flexible Savings Account (FSA) or Health Savings Account (HSA)?

FSA - You are choosing how much to set aside for healthcare costs, and funding your own account with pre-tax dollars. The benefit is saving in taxes and having access to FSA dollars upfront to spend on healthcare; however, you may risk losing money at the end of the year if the funds aren't spent.

HSA - Your employer is funding your HSA depending on how many people are on your plan (Single, Double, Family), which covers more than half of your deductible! You have the option to add your payroll contributions too, and this money rolls over year-to-year if you don't spend it!

Did you know?

FSA and HSA funds can be used to pay for more than just services covered by your medical, dental, or vision plan. You can also use funds for braces, LASIK, glasses/contacts, certain over-the-counter medications, and more. Search for qualifying expenses at https://healthequity.com/qme.

Medical Plans

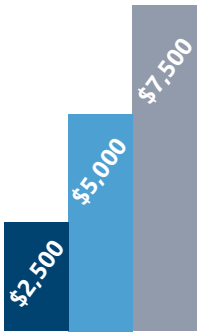
A STAR HSA Plan

Single Double Family

Your Annual Cost	Employer HSA Contribution
Single $0	Single $1,190.28
Double $0	Double $2,405.00
Family $0	Family $2,678.26

Medical Deductible
Medical & Pharmacy

Out-of-Pocket Maximum (OOPM)
Medical & Pharmacy



Plan Benefits

PEHP pays 80% coinsurance after deductible and you pay 20% coinsurance until you reach your OOPM.

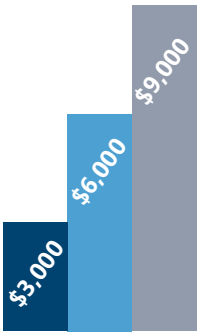
Review coverage and benefit details on page 6.

B Traditional Plan

Your Annual Cost	Employer HSA Contribution
Single $445.90	Single $0
Double $919.10	Double $0
Family $1,226.94	Family $0

Medical Deductible
Medical & Pharmacy

Out-of-Pocket Maximum*
Medical & Pharmacy



Plan Benefits

Review coverage and benefit details on page 9.

*per individual

Plans at a Glance

A STAR HSA Plan

» You pay 2% of the premium, and your employer pays 98%.

» You get money in an HSA for health-related expenses to offset a higher deductible. HSA funds carry over from year-to-year and grow tax-free. You never forfeit what you don't spend.

» It covers more preventive services paid at 100% compared to other plans, including chronic medications like diabetes. See a list of medications on page 19 of the Covered Drug List at www.pehp.org/pharmacy.

B Traditional Plan

» You pay 8% of the premium, and your employer pays 92%.

» It has a lower deductible and gives you predictable costs through fixed co-pays.

» Each family member has their own deductible and out-of-pocket maximum.

» Deductible does not apply to out-of-pocket maximum.

» You have the option to add on a Flexible Spending Account (FLEX$) for qualified health expenses, which is funded through pre-tax payroll deductions.

C Opt-Out Cash Benefit

If you have other medical insurance coverage, you can opt-out of PEHP medical coverage in exchange for more money annually:

» Single: **$2,000.18**

» Double/Family: **$4,000.10**

» To opt-out, go to the Medical section of online enrollment. Click "Change" then select "Opt Out" from the available plans.

» Income is subject to tax.

» Please do not cancel/terminate your current medical plan. You must enroll in the Opt-Out option by May 18.

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
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit after deductible	Not applicable
PEHP Value Clinics	**Medical:** 20% after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	20% after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	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
Mental Health and Substance Abuse *Treatment for Autism at in-network providers only, requires Preauthorization*	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 *Medical 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 *Requires Preauthorization*	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require Preathorization.* *See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.* *Residential Treatment benefit: up to 60-day limit applies, no out-of-network coverage*	20% after deductible	40% after deductible

	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
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
PROFESSIONAL SERVICES		
PEHP e-Care	**Medical:** $10 co-pay per visit	Not applicable
PEHP Value Clinics	$10 co-pay per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$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 and inpatient visits*	$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
Mental Health and Substance Abuse *Treatment for Autism at in-network providers only, requires Preauthorization*	$35 co-pay per visit **University of Utah Medical Group:** $45 co-pay per visit	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 *Medical 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 *Requires Preauthorization*	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility *Non-custodial. Up to 60 days per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Up to 45 days per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization.* *Residential Treatment benefit: up to 60-day limit applies, no out-of-network coverage*	20% after deductible	40% after deductible

	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
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

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

See rates on page 23

Preferred

- 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

- 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

Regence Expressions

- 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

SEE MORE DENTAL OPTIONS

IMPORTANT INFORMATION

Cancel Coverage » If you cancel PEHP dental coverage and don't have other dental insurance coverage, you'll have to wait 3 years to reenroll in a PEHP dental plan.

Waiting Period » 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. 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.

Dental Plans (continued)

Opt-Out Cash Benefit

If you have other dental insurance coverage, you can opt-out of dental coverage in exchange for more money each paycheck

- Single: $3.85
- Double: $7.70
- Family: $15.35
- To opt-out, go to the Dental section of online enrollment. Click "Change" then select "Opt-Out" from the available plans.
- Income is subject to tax
- If you waive PEHP dental coverage and don't have other dental coverage, you will be eligible to reenroll in a PEHP dental plan only if you have proof of other dental coverage or at least 3 years have passed since you waived PEHP dental coverage.

SEE MORE DENTAL OPTIONS

Utah Housing Corporation Benefits Guide

EFFECTIVE: JULY 1, 2022–JUNE 30, 2023
OPEN ENROLLMENT: APRIL 18–MAY 18, 2022

Main Menu

	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

State Of Utah

Regence Expressions℠ ValueCare

Effective July 1, 2022 through June 30, 2023

Regence

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

This plan includes preventive and diagnostic services, as well as restorative and major services. After satisfaction of the deductible, this plan will provide payment for the services at the percentages listed below up to the calendar year maximum. Payment of benefits is based on a percentage of the Allowed Amount. Participating providers have agreed to accept the Allowed Amounts as payment for services. Services of a Nonparticipating provider are based on a percentage of the Allowed Amount. The Member will be responsible for any additional charges over the Allowed Amount.

Cost Share Details		Participating	Nonparticipating
Annual Deductible	The total deductible you pay per plan year	$0 Individual $0 Family	
Annual Limit	The combined total for your deductible, coinsurance and copays per plan year	$1,500 Individual	

Preventive and Diagnostic Dental Services		What You Pay
Cleanings and Examinations	Cleanings - 2 per plan year with Preventive oral examinations - 2 per plan year	Covered in full
X-rays	Bitewing x-rays - 2 sets per plan year Complete intra-oral mouth x-ray - Once in a 3-year period Panoramic mouth x-ray - Once in a 3-year period	Covered in full
Other Preventive Dental Services	Sealants (permanent bicuspids and molars only) for members under 15 years of age Space maintainers for members under 13 years of age Topical fluoride application - 2 per plan year for members under 26 years of age	Covered in full

Basic Dental Services		What You Pay
Complex Oral Surgery	Including surgical extraction of teeth	20%
Emergency and Other Basic Dental Services	Emergency treatment for pain relief	20%
Endodontic Services	Services including root canal treatment, pulpotomy and apicoectomy	20%
Periodontal Services	Periodontal maintenance - 2 per plan year (in lieu of preventive cleanings) Debridement - Once in a 3-year period Scaling and root planing - 1 in a 2-year period per quadrant	20%

Major Dental Services		What You Pay
Bridges (fixed partial dentures)	Replacement once per 5 years after placement	50%
Crowns, Inlays and Onlays	Replacement once (per tooth) 5 years after placement	50%
Dentures (full and partial)	Replacement 5 years after placement	50%
Implants (endosteal)		50%

Orthodontia Services		What You Pay
Orthodontia Services	$1,500 per lifetime 0 month waiting period	50%

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY.** Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

Funding Through Opticare

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 rates on page 23

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 rates on page 23

OpticareVision

OPTICARE PLAN:

0-150/140C - Full Plan

Products/Services	Select Network	Broad Network	Out-Of-Network
Eye Exam			
Comprehensive Eye Exam	100% Covered	$10 Co-pay	$40 Allowance
Retail Imaging	$20 Co-pay	$39 Co-pay	
Contact fitting Standard Spherical	$0 Co-pay - Covered 100%	$40 Co-pay	
Speciality Toric or Multifocal	$40 Co-pay	$80 Co-pay	
Routine Dilation	100% Covered	100% Covered	Included above
Standard Plastic Lenses			
Single Vision	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Bifocal (FT 28)	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Trifocal (FT 7x28)	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Standard Progressive	$30 Co-pay	$50 Co-pay	
Digital Progressive (MasterpieceHD)	$80 Co-pay	$100 Co-pay	
Options & Coatings			
UV	$0 Co-pay - 100% Covered	$10 Co-pay	Included Above
Tint	$0 Co-pay - 100% Covered	$10 Co-pay	
Scratch	$0 Co-pay - 100% Covered	$10 Co-pay	
Polycarbonate Kids (Under age 19)	$20 Co-pay	$40 Co-pay	
Polycarbonate Adults	$40 Co-pay	$40 Co-pay	
Premium Anti-Reflective	$50 Co-pay	25% Dicount	
Transitions/Photochromic	$50 Co-pay	$75 Co-pay	
BluDefense Digital (includes AR)	$100 Co-pay	NA	
Polarized	25% Discount	0-25% Discount	
Other Add-ons	25% Discount	0-25% Discount	
Frames			
Allowance Based on Retail Pricing	$150 Allowance	$130 Allowance	$70 Allowance
Additional Eyewear Throughout the Year	50% Off Reatil	25-50% Off Retail	
Contacts			
Contact benefits is in lieu of lens and frame benefit.	$140 Allowance	$130 Allowance	$100 Allowance
Medically Necessary Contacts	$0 Co-pay - Covered 100%	$250 Allowance	NA
Additional Contact Purchases	Up to 20% off Discount	Up to 10% Discount	
Non-RX (Plano Sunglasses)	25% Discount	20% Discount	
All other options	25% Discount	20% Discount	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months

OpticareVision Services

OPTICARE PLAN:

150/140C - Eyewear Only Plan

Products/Services	Select Network	Broad Network	Out-Of-Network
Standard Plastic Lenses			
Single Vision	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Bifocal (FT 28)	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Trifocal (FT 7x28)	$0 Co-pay - 100% Covered	$10 Co-pay	$70 Allowance for lenses, options, and coatings
Standard Progressive	$30 Co-pay	$50 Co-pay	
Digital Progressive (MasterpieceHD)	$80 Co-pay	$100 Co-pay	
Options & Coatings			
UV	$0 Co-pay - 100% Covered	$10 Co-pay	Included Above
Tint	$0 Co-pay - 100% Covered	$10 Co-pay	
Scratch	$0 Co-pay - 100% Covered	$10 Co-pay	
Polycarbonate Kids (Under age 19)	$20 Co-pay	$40 Co-pay	
Polycarbonate Adults	$40 Co-pay	$40 Co-pay	
Premium Anti-Reflective	$50 Co-pay	25% Dicount	
Transitions/Photochromic	$50 Co-pay	$75 Co-pay	
BluDefense Digital (includes AR)	$100 Co-pay	NA	
Polarized	25% Discount	0-25% Discount	
Other Add-ons	25% Discount	0-25% Discount	
Frames			
Allowance Based on Retail Pricing	$150 Allowance	$130 Allowance	$70 Allowance
Additional Eyewear Throughout the Year	50% Off Reatil	25-50% Off Retail	
Contacts			
Contact benefits is in lieu of lens and frame benefit.	$140 Allowance	$130 Allowance	$100 Allowance
Medically Necessary Contacts	$0 Co-pay - Covered 100%	$250 Allowance	NA
Additional Contact Purchases	Up to 20% off Discount	Up to 10% Discount	
Non-RX (Plano Sunglasses)	25% Discount	20% Discount	
All other options	25% Discount	20% Discount	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Refractive Surgery			
LASIK	20% Off Retail or 10% off promo price	NA	NA
Visian ICL	20% Off Retail or 10% off promo price	NA	NA

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	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
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
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and 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	Up to $200
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	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 from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

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. 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; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. 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 the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits. 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.

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
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
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and 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	Up to $200
EXAM SERVICES		
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**
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

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. No benefits will be paid for services or materials connected with or charges arising from: any Vision Examination; medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; 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; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. 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 the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits. 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.

UTAH HOUSING!

MEDICAL INSURANCE CONTRIBUTIONS
BI-MONTHLY*
JULY 2022 - JUNE 2023

Months with 3 pay periods, PEHP medical, dental, vision & life insurance deductions will only be taken out for 2 pay periods.
H$A contributions (Employer & Employee), Flex Spending Accts & Aflac deductions will still be made/taken each pay period (26).

*****Opt-Out Cash Benefit*****

Allows employees with other medical/dental coverage to waive employer-sponsored coverage in exchange for a monetary benefit.
PEHP will assist with enrollment and verification, by adding Opt-Out as a plan option in online enrollment for either Medical or Dental.

BI-MONTHLY MEDICAL CONTRIBUTIONS

PEHP TRADITIONAL PLANS ADVANTAGE / SUMMIT	Employer Monthly	**Employee Bi-monthly**	Total Monthly	**UHC - H$A Contribution**
SINGLE	$ 651.44	**$ 17.15**	$ 685.74	$ -
DOUBLE	$ 1,343.16	**$ 35.35**	$ 1,413.86	$ -
FAMILY	$ 1,793.08	**$ 47.19**	$ 1,887.46	$ -

STAR PLANS H$A ADVANTAGE/SUMMIT (STAR)	Employer Monthly	**Employee Bi-monthly**	Total Monthly	**UHC - H$A Contribution (Per 26 PP)**
SINGLE	$ 552.26	**0.00**	**$ 552.26**	**$ 45.78**
DOUBLE	$ 1,142.74	**0.00**	**$ 1,142.74**	**$ 92.50**
FAMILY	$ 1,569.90	**0.00**	**$ 1,569.90**	**$ 103.01**

UHC Advantage/Summit Star Plan Contributions:

** **SINGLE H$A Plan: $1,190.28 per year / $45.78 per 26 pay periods**
** **DOUBLE H$A Plan: $2,405.00 per year / $92.50 per 26 pay periods**
** **FAMILY H$A Plan: $2,678.26 per year / $103.01 per 26 pay periods**

Annual Medical Opt-Out Cash Benefit Incentive (paid biweekly)
Single - $2,000.18 ($76.93/paycheck
Double/Family - $4,000.10 ($153.85/paycheck)
Annual Dental Opt-Out Cash Benefit Incentive (paid biweekly)
Single - $100.10 ($3.85/paycheck
Double - $200.20 ($7.70/paycheck
Family - $399.10 ($15.35/paycheck)
These amounts will show as earnings on your paycheck.

BI-MONTHLY DENTAL CONTRIBUTIONS

PEHP DENTAL *TRADITIONAL*		Employer Monthly	**Employee Bi-monthly**	Total Monthly
	SINGLE	$ 26.04	**$ 2.61**	$ 31.26
	DOUBLE	$ 48.32	**$ 4.85**	$ 58.02
	FAMILY	$ 88.00	**$ 8.82**	$ 105.64
PREFERRED CHOICE ($25 deductible)				
	SINGLE	$ 26.02	**$ 1.45**	$ 28.92
	DOUBLE	$ 48.32	**$ 2.69**	$ 53.70
	FAMILY	$ 87.94	**$ 4.89**	$ 97.72
REGENCE EXPRESSIONS DENTAL				
	SINGLE	$ 35.02	**$ 5.23**	$ 45.48
	DOUBLE	$ 63.36	**$ 9.47**	$ 82.30
	FAMILY	$ 113.98	**$ 17.03**	$ 148.04

BI-MONTHLY VISION CONTRIBUTIONS

		Employer monthly	**Employee bi-monthly**	Total Monthly
EYEMED Full	SINGLE	$ -	**$ 3.69**	$ 7.38
	DOUBLE	$ -	**$ 5.97**	$ 11.94
	FAMILY	$ -	**$ 8.24**	$ 16.48
EYEMED Eyewear Only	SINGLE	$ -	**$ 3.20**	$ 6.40
	DOUBLE	$ -	**$ 5.03**	$ 10.06
	FAMILY	$ -	**$ 6.85**	$ 13.70
OPTICARE Full	SINGLE	$ -	**$ 4.35**	$ 8.70
	DOUBLE	$ -	**$ 6.71**	$ 13.42
	FAMILY	$ -	**$ 9.57**	$ 19.14
OPTICARE Eyewear Only	SINGLE	$ -	**$ 3.40**	$ 6.80
	DOUBLE	$ -	**$ 5.04**	$ 10.08
	FAMILY	$ -	**$ 7.04**	$ 14.08

Version 04.12.22 sfc

Wellness & Value Added Benefits

PEHP Healthy Utah & Wellness Rebates

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

Subscribers and their spouses are eligible to attend one Healthy Utah biometric testing session each plan year free of charge.

FOR MORE INFORMATION

PEHP Healthy Utah
801-366-7300 or 855-366-7300
» **Email:** healthyutah@pehp.org
» **Web:** www.pehp.org/wellness
» **Rebates:** www.pehp.org/rebates

PEHP WeeCare

PEHP WeeCare is a pregnancy and postpartum program provided to support and educate PEHP members. PEHP WeeCare's goal is to help expectant mothers have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy.

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

FOR MORE INFORMATION

PEHP WeeCare
P.O. Box 3503
Salt Lake City, Utah 84110-3503
801-366-7400 | 855-366-7400
» **E-mail:** weecare@pehp.org
» **Web:** www.pehp.org/weecare

PEHP Wellness Programs

As a PEHP member, you have access to wellness programs and activities to help you stay on top of your health. Below are some of the programs you can participate in:

- Health Coaching – Meet your health and weight management goals with personalized help from a health coach
- Wellness Challenges – Improve your physical and mental well-being in a new and challenging way every month
- Diabetes Management – Receive education and support from a registered dietitian to manage or prevent diabetes
- Workout Warrior – Stay active and physically fit with weekly motivational tips and resources from a certified personal trainer

FOR MORE INFORMATION

PEHP Wellness Programs
801-366-7300 | 855-366-7300
» **E-mail:** healthyutah@pehp.org
» **Web:** www.pehp.org/wellness

Mental Health Care & Resources

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

FOR MORE INFORMATION

Blomquist Hale, 800-926-9619

» **Web:** www.blomquisthale.com

Find other resources at www.pehp.org/mentalhealth

PEHP Health & Benefits

Utah Housing Corporation

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Wellness & 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.

Preventive Medications Covered Before Deductible

If you're on the STAR HSA Plan, certain chronic medications are covered before you meet your deductible. See a list of medications on page 19 of the Covered Drug List.

Bariatric Surgery

Bariatric surgery is covered when done by specific in-network providers. Preauthorization is required. Call PEHP to learn more about this benefit, 801-366-7555 or 800-765-7347.

E-Care Benefit

Need Immediate Care? Consult a Doctor Remotely. With your PEHP E-Care benefit you have access to care for urgent needs such as:

» COVID-19 Symptoms

» Eye infections

» Painful urination

» Joint pain or strains

» Minor skin problems

FOR MORE INFORMATION

» **Web:** www.pehp.org/ecare

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

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.

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

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Life Assistance Counseling

Blomquist Hale SOLUTIONS

WHEN LIFE GETS CHALLENGING WE CAN HELP

The Blomquist Hale Life Assistance Counseling program provides direct, **face-to-face** guidance to address virtually any stressful life situation or problem. Not to mention there is absolutely **no cost** to you. Meeting with our team is simple. Call to schedule an appointment today. **(800) 926-9619**

Count On:

- ☑ 24/7 Crisis Service
- ☑ 100% Confidential
- ☑ Professional, Friendly Team
- ☑ Convenient Locations
- ☑ Extended Hours
- ☑ No Co-pay Required

WE CAN HELP WITH

- Marital & Family Counseling
- Stress, Anxiety or Depression
- Personal & Emotional Challenges
- Grief or Loss
- Financial or Legal Problems
- Substance Abuse or Addictions
- Senior Care Planning

To register for our no cost online webinars, please go to:
https://blomquisthale.com/Work-Shops.html

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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

PEHP Life & Accident

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

COVERAGE	AMOUNT
Up to Age 70	25,000
Age 71 to 75	12,500
Age 76 and over	6,250

LINE-OF-DUTY DEATH BENEFIT

If you're enrolled in basic coverage, you get an additional $50,000 Line-of-Duty Death Benefit at no extra cost. Enrollment is automatic.

ACCIDENTAL DEATH RIDER

If you're enrolled in basic coverage, you get an additional $10,000 Accidental Death Benefit, subject to the provisions of the PEHP Group Accident Plan, at no extra cost. Enrollment is automatic.

EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

- You want more coverage than the guaranteed issue;
- You apply for any amount of coverage 60 days after your hire date.

After you apply for coverage, PEHP will guide you through the necessary steps to get evidence of insurability. They may include:

- Completing a health questionnaire;
- Basic biometric testing and blood work;
- Furnishing your medical records.

EMPLOYEE ADDITIONAL TERM COVERAGE

If you apply within 60 days of your hire date, you can purchase up to $200,000 as guaranteed issue. After 60 days, or for coverage greater than $200,000 you must provide evidence of insurability.

Biweekly Rates	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 35	1.10	1.66	2.21	3.31	4.42	5.52	6.63	7.73	8.84	9.94	11.05
Age 35 to 39	1.38	2.07	2.76	4.14	5.52	6.90	8.29	9.67	11.05	12.43	13.81
Age 40 to 44	1.93	2.90	3.87	5.80	7.73	9.67	11.60	13.53	15.47	17.40	19.33
Age 45 to 49	2.85	4.28	5.71	8.56	11.41	14.27	17.12	19.98	22.83	25.68	28.54
Age 50 to 54	4.24	6.35	8.47	12.70	16.94	21.17	25.41	29.64	33.88	38.11	42.35
Age 55 to 59	6.17	9.25	12.34	18.50	24.67	30.84	37.01	43.17	49.34	55.51	61.68
Age 60 to 64	9.11	13.67	18.23	27.34	36.45	45.57	54.68	63.79	72.91	82.02	91.13
Age 65 to 69	12.61	18.92	25.22	37.84	50.45	63.06	75.67	88.28	100.89	113.50	126.11
After age 69, rates remain constant and coverage changes											
Coverage Amounts	12.61	18.92	25.22	37.84	50.45	63.06	75.67	88.28	100.89	113.50	126.11
Age 70 to 74	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life & Accident

SPOUSE TERM COVERAGE

If you apply within 60 days of your hire date or date of marriage, you can purchase up to $50,000 as guaranteed issue for your spouse. After 60 days, or for coverage greater than $50,000 you will need evidence of insurability.

Biweekly Rates	25,000	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 35	0.55	1.10	1.66	2.21	3.31	4.42	5.52	6.63	7.73	8.84	9.94	11.05
Age 35 to 39	0.69	1.38	2.07	2.76	4.14	5.52	6.90	8.29	9.67	11.05	12.43	13.81
Age 40 to 44	0.97	1.93	2.90	3.87	5.80	7.73	9.67	11.60	13.53	15.47	17.40	19.33
Age 45 to 49	1.43	2.85	4.28	5.71	8.56	11.41	14.27	17.12	19.98	22.83	25.68	28.54
Age 50 to 54	2.12	4.24	6.35	8.47	12.70	16.94	21.17	25.41	29.64	33.88	38.11	42.35
Age 55 to 59	3.08	6.17	9.25	12.34	18.50	24.67	30.84	37.01	43.17	49.34	55.51	61.68
Age 60 to 64	4.56	9.11	13.67	18.23	27.34	36.45	45.57	54.68	63.79	72.91	82.02	91.13
Age 59 to 69	6.31	12.61	18.92	25.22	37.84	50.45	63.06	75.67	88.28	100.89	113.50	126.11
After age 69, rates remain constant and coverage changes												
Coverage Amounts	6.31	12.61	18.92	25.22	37.84	50.45	63.06	75.67	88.28	100.89	113.50	126.11
Age 70 to 74	12,500	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	6,250	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

If you apply within 60 days of your hire date, you can purchase any available amount of coverage for dependent children. After 60 days, any new application for coverage, or increase in coverage, will require evidence of insurability. All eligible children will be covered at the same level.

Coverage Amount	5,000	10,000	15,000
Biweekly cost	0.24	0.48	0.72

Accidental Death and Dismemberment (AD&D)

AD&D provides benefits for death, loss of use of limbs, speech, hearing or eye sight due to an accident, subject to the limitations of the policy.

INDIVIDUAL PLAN

You can select a coverage amount ranging from $25,000 to $250,000.

FAMILY PLAN

- You can select a coverage amount ranging from $25,000 to $250,000, and your spouse and dependents will be automatically covered as follows:
  - Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;
  - Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.
- If injury to an insured person covered for this benefit results within one year of the date of the accident in any of the losses set forth, the plan will pay the sum specified opposite such loss, but the total amount payable for all such losses as a result of any one accident will not exceed the Principal Sum applicable to the insured person. The Principal Sum applicable to the insured person is the amount specified on the enrollment form.

FOR LOSS OF	BENEFIT PAYABLE
Life	**Principal Sum**
Two Limbs	Principal Sum
Sight of Two Eyes	**Principal Sum**
Speech and Hearing (both ears)	Principal Sum
One Limb or Sight of One Eye	**Half Principal Sum**
Speech or Hearing (both ears)	Half Principal Sum
Use of Two Limbs	**Principal Sum**
Use of One Limb	Half Principal Sum
Thumb and Index Finger On Same Hand	**Quarter Principal Sum**
Thumb or Index Finger	Eighth Principal Sum
Any Two Fingers on One Hand	**Tenth Principal Sum**

*Total benefit for loss of digits on one hand shall not exceed 25%. Benefits may not be combined upon the loss of multiple digits.

PEHP Life & Accident

Accidental Death and Dismemberment (AD&D)

Additional AD&D Coverage and Cost

INDIVIDUAL PLAN		FAMILY PLAN
Coverage Amount	Biweekly Cost	Biweekly Cost
25,000	0.20	0.29
50,000	0.39	0.58
75,000	0.59	0.86
100,000	0.78	1.15
125,000	0.98	1.44
150,000	1.17	1.73
175,000	1.37	2.01
200,000	1.57	2.30
225,000	1.76	2.59
250,000	1.96	2.88

LIMITATIONS AND EXCLUSIONS

Refer to the Group Term Life and Accident Plan Master Policy for details on plan limitations and exclusions. Call 801-366-7495 or visit www.pehp.org for details.

Master Policy

This brochure provides only a brief overview. Complete terms and conditions are available in the Group Term Life and Accident Plan Master Policy. It's available when you log in to PEHP for Members at www.pehp.org. Or request a copy by emailing publications@pehp.org.

560 East 200 South
Salt Lake City, UT 84102-2004
801-366-7495 | 800-753-7495
www.pehp.org

Accident Weekly Indemnity

- Employee coverage only
- If you enroll in AD&D coverage, you may also purchase Accident Weekly Indemnity coverage, which will provide a weekly income if you are totally disabled due to an accident that is not job-related.
- The maximum eligible weekly amount is based on your monthly gross salary at the time of enrollment. You may purchase a lower amount of coverage than the eligible monthly gross salary, but may not buy coverage for more than the eligible monthly gross salary.

Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	BIWEEKLY COST
250 and under	25	0.11
251 to 599	50	0.20
600 to 700	75	0.29
701 to 875	100	0.40
876 to 1,050	125	0.50
1,051 to 1,200	150	0.60
1,201 to 1,450	175	0.69
1,451 to 1,600	200	0.80
1,601 to 1,800	225	0.89
1,801 to 2,164	250	0.99
2,165 to 2,499	300	1.18
2,500 to 2,899	350	1.38
2,900 to 3,599	400	1.58
3,600 and over	500	1.97

Accident Medical Expense

- Employee coverage only
- This benefit is available to help you pay for medical expenses that are in excess of those covered by all group insurance plans and no-fault automobile insurance.
- This benefit will provide up to $2,500 to help cover medical expenses incurred due to an accident that is not job-related.

Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	BIWEEKLY COST
$2,500	$0.46

PEHP Health & Benefits

Utah Housing Corporation

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OPEN ENROLLMENT: APRIL 18–MAY 18, 2022

Health Accounts

Health Savings Account (HSA)

An HSA is like a flex account, but better. You never have to worry about forfeiting HSA money you don't spend – it carries over year-to-year and employer-to-employer. Money goes in tax-and-FICA-free, grows tax-free, and can be used for eligible expenses tax-free.

Your employer helps fund your HSA account. Use it to save for future health needs and retirement, plus make penalty-free withdrawals after age 65. Check with your employer on how much and how often they contribute.

To be eligible for an HSA, the following things must apply:

» You must enroll in an HSA-eligible medical plan.

» You're not covered by a general-purpose flex account (FSA) or HRA (see below) or the balance is $0 before you open an HSA.

» You're not covered by another health plan (unless it's also an HSA-qualified plan).

» You're not covered by Medicare or TRICARE. (If you're already enrolled in Medicare and have an HSA, you can use funds for eligible expenses, but you cannot contribute funds to your HSA account.)

» You're not a dependent of another taxpayer.

HSA contribution limits for calendar year 2022:

Single: $3,650 (Total from employer + employee)

Double/Family: $7,300 (Total from employer + employee)

PEHP will enroll you in the HSA, but HealthEquity administers your HSA account. HealthEquity will issue you a VISA card to pay for eligible expenses or you can submit your receipt and reimburse yourself from your HSA account.

Flexible Spending Account (FLEX$)

FLEX$ is a flexible spending account that saves you money by setting aside a portion of your pre-tax salary to pay eligible expenses. There are two different FLEX$ accounts – one for medical expenses and another to help with dependent childcare costs.

» Great option to save for expenses if you're not eligible for an HSA.

» If you sign up for a FLEX$ account, PEHP will frontload your elected funds at the beginning of the plan year and issue you a Mastercard to use as payment for eligible expenses. Eligible expenses are set by the IRS.

» If you do have an HSA, you can have a limited FLEX$ account to pay for dental, vision, and post-deductible medical expenses only.

» FLEX$ accounts are use-or-lose. You may rollover up to $570 into the new plan year, but anything beyond that is forfeited.

» You must enroll in FLEX$ each year during open enrollment to participate.

You can contribute up to $2,850 in calendar year 2022.

Learn More

PEHP Health & Benefits

Utah Housing Corporation Benefits Guide

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URS Utah Retirement Systems

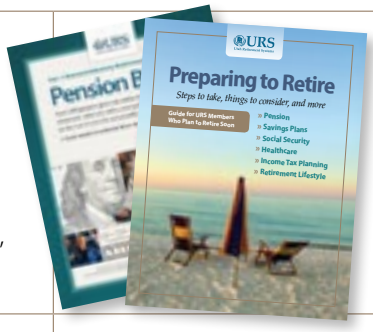
Learn About Your Retirement Benefits

Your Benefits, Your Way

Whatever your style of learning, URS is here to help you understand your retirement benefits.

Website

Go to **www.urs.org** for information about your pension and savings plans. Log in to **myURS** to manage investments, beneficiaries, and more.



Publications

Understand your pension, savings plans options, and more. Find publications at **www.urs.org**. Or email **publications@urs.org** to request printed copies.

Videos

Understand the basics of your retirement benefits, learn how to manage them online, and more. Go to **www.urs.org/us/videos**.

Webinars

Learn at your own computer or device. See schedule at **www.urs.org/us/webinars.** Archived webinars are available.

Seminars

Held throughout the year, seminars provide an overview of your benefits and more. Go to **www.urs.org/us/seminars**.

One-on-One

A URS Retirement Planning Advisor can provide custom retirement guidance. Schedule a free session at **myURS** at **www.urs.org**.

Via Phone

We look forward to answering your questions. Call weekdays between 8 a.m. and 5 p.m., **801-366-7700** or **800-365-8772**.

URS Utah Retirement Systems

Individual Retirement Planning

Let's Work Together for Your Secure Retirement

These free sessions help you financially plan for retirement.

Have questions about your URS benefits? Want some guidance to see if you're on track for a comfortable retirement? Let us help.

Many Ways to Meet

Sessions are available in-person at the URS Salt Lake City office and workplaces throughout Utah, or virtually. To register for a session, log in to myURS at **www.urs.org.**

We'll Help You Answer These Questions and More:

- » Am I on track for retirement?
- » What are my retirement needs, and how can I meet them?
- » Which Tier 2 retirement option should I choose?
- » Which URS savings plan and investment options are right for me?
- » What pension payout option is right for me?
- » How much should I be saving?

Learn more at www.urs.org/us/counseling or call 801-366-7470.

PEHP Health & Benefits

Utah Housing Corporation Benefits Guide

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Utah Housing Corporation Benefits Guide

UTAH HOUSING CORPORATION

Benefits Guide

Effective July 2022

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

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

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

The information in this Benefits Guide is distributed on an "as is" basis, without warranty. While every precaution has been taken in the preparation of this Benefits Summary, PEHP shall not incur any liability due to loss, or damage caused or alleged to be caused, directly or indirectly by the information contained in this Benefits Summary.

The information in this Benefits Guide is intended as a service to members of PEHP. While this information may be copied and used for your personal benefit, it is not to be used for commercial gain.

The employers participating with PEHP are not agents of PEHP and do not have the authority to represent or bind PEHP.