

2023-2024

# Open Enrollment

Utah Communications Authority COBRA

Look inside for an overview of your benefits and rates for the 2023-24 plan year.



**PEHP**  
Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES



**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](http://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 entire monthly rates shown in this packet.

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

Sincerely,

PEHP Enrollment

<b>State Risk Pool COBRA Rates</b>			
<b>Monthly Rates Effective July 1, 2023 - June 30, 2024</b>			
<b>Medical Plans - Advantage &amp; Summit</b>	<b>Single</b>	<b>Double</b>	<b>Family</b>
STAR HSA	\$607.81	\$1,257.35	\$1,723.88
Traditional	\$748.04	\$1,542.32	\$2,058.95
Consumer Plus	\$517.87	\$1,077.28	\$1,542.30
<b>Dental Plans</b>	<b>Single</b>	<b>Double</b>	<b>Family</b>
Preferred Dental	\$29.78	\$55.28	\$100.61
Traditional Dental	\$32.19	\$59.73	\$108.73
Basic HSA Dental	\$20.28	\$37.64	\$68.42
Discount HSA Dental	\$1.31	\$2.43	\$4.39
EMI Choice Indemnity Dental	\$40.83	\$71.92	\$127.43
<b>Vision Plans</b>	<b>Single</b>	<b>Double</b>	<b>Family</b>
EyeMed Full	\$7.61	\$12.26	\$16.88
EyeMed Eyewear Only	\$6.61	\$10.33	\$14.06
Opticare Full	\$8.43	\$12.62	\$18.01
Opticare Eyewear Only	\$6.53	\$9.63	\$13.03

If you have any questions, please call customer service at (801) 366-7555 or toll free at (800)765-7347.  
Review this packet to find out which plans are available to you.

## Important Links

[Creditable Coverage Letter](#)

[Important Benefits Notices](#)

[Glossary of Health Coverage and Medical Terms](#)



560 East 200 South, Salt Lake City, UT 84102  
 801-366-7555 / 800-765-7347  
 Fax: 801-366-7599  
 www.pehp.org

# Medical, Dental, Vision Enrollment and Change Form State Risk Pool COBRA

**Important Note:** Changes made on this form will affect your medical, dental, and vision coverages only. If you need to make changes to other coverages, please complete the appropriate forms for those plans. **Please print clearly.**

Termination \_\_\_\_\_ Annual Enrollment Change Request (Please Specify Type): \_\_\_\_\_

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS SINGLE MARRIED	GENDER MALE FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE		

**Group Medical (check one)**

**Coverage type (Check one)**

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus two or more dependents
- No medical coverage at this time

**Choose your network**

- Summit Network
- Advantage Network

**Choose your medical plan**

- STAR HSA
- Traditional
- Consumer Plus
- Consumer Plus is only available to members previously enrolled in STAR HSA.*

**Group Dental (check one)**

**Coverage type (Check one)**

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus two or more dependents

**Choose your dental plan**

- PEHP Preferred Dental
- PEHP Traditional Dental
- EMI Choice Indemnity
- No dental coverage at this time

**Additional options for those on STAR HSA or Consumer Plus Plan Only:**

- Basic HSA Dental
- Discount HSA Dental

**VISION (Check one)**

- Eyemed – Full
- Eyemed – Eyewear Only
- Opticare – Full
- Opticare – Eyewear Only
- No vision coverage at this time

**Coverage type (Check one)**

- EMPLOYEE ONLY
- Employee plus one dependent
- Employee plus 2+ dependents

**ADDITIONS** List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. PEHP benefits will not be processed until required documentation is received.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
<b>CODE KEY:</b> <b>S</b> » Legal Spouse			Male Female			Medical Dental Vision
<b>C</b> » Child Natural/Adopted			Male Female			Medical Dental Vision
<b>SC</b> » Stepchild			Male Female			Medical Dental Vision
<b>O</b> » Other (Describe in Explanations)			Male Female			Medical Dental Vision

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? **Yes No** If yes, complete Multiple Group Coverage Section on back

**REMOVALS** Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO EMPLOYEE	FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE*	COVERAGE TERMINATED
<b>S</b> » Legal Spouse					Medical Dental Vision
<b>C</b> » Child Natural/Adopted					Medical Dental Vision
<b>SC</b> » Stepchild					Medical Dental Vision
<b>O</b> » Other (Describe in Explanations)					Medical Dental Vision

\*Applicable Date is the date of marriage, divorce, birthday, etc.

**Signature required on other side.**

<b>(HR use only)</b>	<b>ST-C</b>	5-5-23
Effective Date: _____	Termination Date: _____	HR Approval: _____

# Page 2: Medical Dental, Vision | State Risk Pool COBRA

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	Effective Date (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDANTS COVERED BY PLAN (Only first name is needed)
				Health Dental	Employee Retired	A A&B	
				Health Dental	Employee Retired	A A&B	

## Explanations

## Employee Agreement and Signature

Before signing, make sure that all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and or documentation. Please note: It is the employee's responsibility to notify PEHP within **60 days of any changes** effecting coverage and/or dependent eligibility (e.g., birth marriage, divorce, etc.).

I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP for any claims paid in error; (5) agree to the terms and conditions in the PEHP Master Policy.

I certify that I am not a party to a divorce proceeding and am not subject to an injunction/order which prevents me from modifying insurance or changing beneficiaries.

Employee Signature	Date
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Please make a copy for your records.



**STAR HSA**

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

	<b>In-Network Provider</b>	<b>Out-of-Network Provider*</b> <i>Balance billing may apply</i>
<b>DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS</b>		
<b>Plan year Deductible</b> <i>Applies to Out-of-Pocket Maximum</i>	Single plans: \$1,500 Double/family plans: \$3,000 <i>One person or a combination can meet the \$3,000 double/family deductible</i>	
<b>Plan year Out-of-Pocket Maximum</b>	Single plans: \$2,500 Double plans: \$5,000 Family plans: \$7,500 <i>One person or a combination can meet the \$7,500 family maximum</i>	
<b>ANNUAL PREVENTIVE CARE</b>		
<b>Preventive services allowed by Affordable Care Act</b> <i>Annual physical exam, immunizations. See full list at <a href="http://www.pehp.org/preventiveservices">www.pehp.org/preventiveservices</a></i>	No charge	40% after deductible
<b>PEHP VALUE PROVIDERS</b>		
<b>PEHP Value Providers</b> <i>Cash Back opportunities available. Visit <a href="http://www.pehp.org/valueproviders">www.pehp.org/valueproviders</a></i>	20% after deductible	Not applicable
<b>PROFESSIONAL SERVICES</b>		
<b>Primary Care Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Specialist Visits</b> <i>Includes office surgeries, inpatient visits and Autism services</i>	20% after deductible	40% after deductible
<b>Surgery and Anesthesia</b>	20% after deductible	40% after deductible
<b>Emergency Room Specialist Visits</b>	20% after deductible	20% after deductible
<b>Diagnostic Tests, Labs, X-rays</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>   <i>All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at <a href="http://www.pehp.org">www.pehp.org</a></i>		
<b>30-day Pharmacy</b> <i>Retail only</i>	<b>Tier 1:</b> \$10 co-pay <b>Tier 2:</b> 25% of discounted cost. \$25 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
<b>90-day Pharmacy</b> <i>Maintenance only</i>	<b>Tier 1:</b> \$20 co-pay <b>Tier 2:</b> 25% of discounted cost. \$50 minimum, no maximum co-pay <b>Tier 3:</b> 50% of discounted cost. \$100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

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

\*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

SRP 2023-24 » Medical Benefits Grid » STAR HSA

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

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



**Traditional** (Non-HSA)

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

**In-Network Provider**

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

*Balance billing may apply*

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


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

\*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

SRP 2023-24 » Medical Benefits Grid » Traditional

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

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

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,500 single/\$3,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care received from <u>network providers</u> is not subject to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No	You do not have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 single/\$5,000 double/\$7,500 family for <u>network providers</u> . No <u>out-of-pocket limit</u> for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and healthcare this <u>plan</u> doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.pehp.org">www.pehp.org</a> or call 1-800-765-7347 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% of <u>Allowed Amount (AA)</u> after <u>deductible</u> PEHP Value Clinics: 20% of AA after <u>deductible</u>	40% of <u>Allowed Amount (AA)</u> after <u>deductible</u>	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.
	Specialist visit	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Preventive care/ screening/immunization	No charge	40% of AA after <u>deductible</u>	*Limited to the Preventive Plus list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed.  *Genetic testing requires <u>pre-authorization</u> .  *Some scans require <u>pre-authorization</u> .
	Imaging (CT/PET scans, MRIs)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> .	Generic drugs (Tier 1)	\$10 co-pay after <u>deductible</u> /retail	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.
	Preferred brand drugs (Tier 2)	25% of discounted cost after <u>deductible</u> /retail. \$25 minimum/no maximum	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost after <u>deductible</u> /retail. \$50 minimum/no maximum	The preferred co-pay after <u>deductible</u> plus the difference above the discounted cost	
	Specialty drugs (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	*PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require <u>pre-authorization</u> .
	Physician/surgeon fees	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	----None----
	<u>Emergency medical transportation</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	<u>Urgent care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .
	Physician/surgeon fee	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you are pregnant	Office visits	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
	Childbirth/delivery professional services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Childbirth/delivery facility services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*All Out-of-Network and some In-Network provider services require <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires <u>pre-authorization</u> .
	<u>Habilitation services</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% of AA after <u>deductible</u>	Not covered	*No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires <u>pre-authorization</u> .
	<u>Hospice service</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
If your child needs dental or eye care	Children's eye exam	No charge	40% of AA after <u>deductible</u>	*One routine exam per plan year.
	Children's glasses	Not covered	Not covered	----None----
	Children's dental check-up	Not covered	Not covered	----None----

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |  |   |  |   |  |
|--|---|--|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations</li><li>• Bariatric surgery</li><li>• Charges for which a third party, auto insurance, or worker's compensation plan are responsible</li><li>• Chiropractic care from an <u>out-of-network provider</u></li></ul> | <ul style="list-style-type: none"><li>• Complications from any non-covered services, devices, or medications</li><li>• Cosmetic surgery</li><li>• Custodial care and/or maintenance therapy</li><li>• Developmental delay — screening</li><li>• Foot care — routine</li><li>• Glasses</li></ul> | <ul style="list-style-type: none"><li>• Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Nursing — private duty</li><li>• Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines</li><li>• Office visits — charges for after hours or holiday</li></ul> | <ul style="list-style-type: none"><li>• Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP</li><li>• Weight-loss programs</li></ul> |
|--|---|--|---|--|

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Coverage provided outside the U.S.</li><li>• Dental care (Adults or children)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine eye care (Adults and children, exams only)</li></ul> |
|---|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [www.pehp.org](http://www.pehp.org) or 1-800-765-7347.

### Does this Coverage Provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this Coverage Meet the Minimum Value Standard? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711).

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ <b>The plan's overall deductible</b>	\$1,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$7,600</b>
---------------------------	----------------

In this example, Peg would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,220
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,720</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	\$1,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

**This EXAMPLE event includes services like:**

Primary care physician visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,500</b>
---------------------------	----------------

In this example, Joe would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,300</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	\$1,500
■ <b>Specialist copayment</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,500</b>
---------------------------	----------------

In this example, Mia would pay:

Cost sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.



**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.pehp.org](http://www.pehp.org) or call 1-800-765-7347 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$350 person/\$700 family for <u>network providers</u> and out-of-network providers. Doesn't apply to <u>network provider visits</u> or <u>preventive care</u> received from <u>network providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Some <u>network provider visits</u> or preventive care received from <u>network providers</u> are not subject to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or coinsurance may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You do not have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this plan?</b>	\$3,000 person/\$6,000 double/\$9,000 family for <u>network providers</u> . No <u>out-of-pocket limit</u> for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and healthcare this <u>plan</u> doesn't cover. See Benefits Summary.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.pehp.org">www.pehp.org</a> or call 1-800-765-7347 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 co-pay/visit IHC for Summit: \$35 co-pay Univ. of Utah MG: \$35 co-pay PEHP Value Clinics: Starting at \$10 co-pay/visit	40% of <u>Allowed Amount</u> (AA) after <u>deductible</u>	*The following services are not covered: charges for after hours or holiday; acupuncture; screening for developmental delay.  *You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist visit</u>	\$35 co-pay/visit IHC for Summit: \$45 co-pay Univ. of Utah MG: \$45 co-pay	40% of AA after <u>deductible</u>	
	<u>Preventive care/ screening/immunization</u>	No charge	40% of AA after <u>deductible</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% of <u>Allowed Amount</u> after <u>deductible</u>	40% of AA after <u>deductible</u>	*Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed. *Genetic testing requires <u>pre-authorization</u> . *Some scans require <u>pre-authorization</u> .
	Imaging (CT/PET scans, MRIs)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.pehp.org">www.pehp.org</a> .	Generic drugs (Tier 1)	\$10 co-pay/retail	The preferred co-pay plus the difference above the discounted cost	*PEHP formulary must be used. Retail and mail-order prescriptions not refillable until 75% of the total prescription supply within the last 180 days is used; some drugs require step therapy and/or <u>pre-authorization</u> . Enteral formula requires <u>pre-authorization</u> . No coverage for: non-FDA approved drugs; vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication.  *PEHP uses the specialty pharmacy Accredo and Home Health Providers for some specialty drugs; <u>pre-authorization</u> may be required. Using Accredo may reduce your cost.
	Preferred brand drugs (Tier 2)	25% of discounted cost/retail. \$25 minimum/no maximum	The preferred co-pay plus the difference above the discounted cost	
	Non-preferred brand drugs (Tier 3)	50% of discounted cost/retail. \$50 minimum/no maximum	The preferred co-pay plus the difference above the discounted cost	
	<u>Specialty drugs</u> (Tier 4)	Medical - 20% of AA after <u>deductible</u> for Tier A drugs, 30% of AA after <u>deductible</u> for Tier B drugs	Tier A 40% of AA after <u>deductible</u> Tier B 50% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*No coverage for: cosmetic surgery; bariatric surgery. Spinal cord stimulators require <u>pre-authorization</u> .
	Physician/surgeon fees	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% of AA, minimum \$150 co-pay per visit	20% of AA, minimum \$150 co-pay per visit, plus any <u>balance billing</u>	----None----
	<u>Emergency medical transportation</u>	20% of AA after <u>deductible</u>	20% of AA after <u>deductible</u> , plus any <u>balance billing</u>	*Ambulance charges for the convenience of the patient or family are not covered. Air ambulance covered only in life-threatening emergencies and only to the nearest facility where proper medical care is available.
	<u>Urgent care</u>	\$45 co-pay	40% of AA after <u>deductible</u>	----None----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Take home medication from a hospital or other facility unless legally required and approved by PEHP. Inpatient mental health/substance abuse, skilled nursing facilities, inpatient rehab facilities, out-of-network inpatient, out-of-state inpatient and some in-network facilities require <u>pre-authorization</u> .
	Physician/surgeon fee	\$25/\$35 co-pay per visit depending on <u>provider</u> type, 20% of AA after <u>deductible</u> for surgeons fees IHC for Summit: \$45 co-pay Univ. of Utah MG: \$45 co-pay	40% of AA after <u>deductible</u>	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$35 co-pay/visit Univ. of Utah MG: \$45 co-pay	40% of AA after <u>deductible</u>	*No coverage for: milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances. Residential treatment programs require preauthorization and 60 day limit applies. Some of these services may be covered through your employer's Employee Assistance Program or Life Assistance Counseling.
	Inpatient services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
If you are pregnant	Office visits	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
	Childbirth/delivery professional services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	
	Childbirth/delivery facility services	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*All Out-of-Network and some In-Network provider services require <u>pre-authorization</u> . No coverage for custodial care. Maximum of 60 visits per plan year.
	<u>Rehabilitation services</u>	Inpatient: 20% of AA after <u>deductible</u> . Outpatient: \$35 co-pay/visit Univ. of Utah Medical Group: \$45 co-pay	40% of AA after <u>deductible</u>	*Outpatient Physical Therapy (PT) /Occupational Therapy (OT) is limited to 20 combined visits per plan year. Speech Therapy (ST) is limited to a maximum of 60 visits per lifetime. Maintenance therapy and therapy for developmental delay are not covered. Inpatient rehabilitation is limited to 45 days per plan year and requires <u>pre-authorization</u> .
	<u>Habilitation services</u>	Inpatient: 20% of AA after <u>deductible</u> . Outpatient: \$35 co-pay/visit Univ. of Utah Medical Group: \$45 co-pay	40% of AA after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% of AA after <u>deductible</u>	Not covered	*No coverage for custodial care. Maximum of 60 days per plan year.
	<u>Durable medical equipment</u>	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	*Sleep disorder supplies are limited to \$325 in a plan year. One oral sleep appliance is covered every 5 years. Certain equipment requires <u>pre-authorization</u> .
	Hospice service	20% of AA after <u>deductible</u>	40% of AA after <u>deductible</u>	----None----
If your child needs dental or eye care	Children's eye exam	Over age 5 and adults: \$35 co-pay per visit.	40% of AA after <u>deductible</u>	*One routine exam per plan year.
	Children's glasses	Not covered	Not covered	----None----
	Children's dental check-up	Not covered	Not covered	----None----

[\* For more information about limitations and exceptions, see the plan or policy document at [www.pehp.org](http://www.pehp.org).]

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |  |   |  |   |  |
|--|---|--|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Ambulance... charges for the convenience of the patient or family; air ambulance for non-life-threatening situations</li><li>• Bariatric surgery</li><li>• Charges for which a third party, auto insurance, or worker's compensation plan are responsible</li><li>• Chiropractic care from an <u>out-of-network provider</u></li></ul> | <ul style="list-style-type: none"><li>• Complications from any non-covered services, devices, or medications</li><li>• Cosmetic surgery</li><li>• Custodial care and/or maintenance therapy</li><li>• Developmental delay — screening</li><li>• Foot care — routine</li><li>• Glasses</li></ul> | <ul style="list-style-type: none"><li>• Mental Health — milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, situational disturbances</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Nursing — private duty</li><li>• Nutritional supplements, including — vitamins, minerals, food supplements, homeopathic medicines</li><li>• Office visits — charges for after hours or holiday</li></ul> | <ul style="list-style-type: none"><li>• Prescription medications not on the PEHP formulary; non-covered medications used in compounded preparations; oral and nasal antihistamines; replacement of lost, stolen, or damaged medication; take-home medications unless approved by PEHP</li><li>• Weight-loss programs</li></ul> |
|--|---|--|---|--|

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Coverage provided outside the U.S.</li><li>• Dental care (Adults or children)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine eye care (Adults and children, exams only)</li></ul> |
|---|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact the plan at 1-800-765-7347.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [www.pehp.org](http://www.pehp.org) or 1-800-765-7347.

### Does this Coverage Provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this Coverage Meet the Minimum Value Standard? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711).

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ <b>The plan's overall deductible</b>	\$350
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$7,600</b>
---------------------------	----------------

In this example, Peg would pay:

Cost sharing	
Deductibles	\$350
Copayments	\$0
Coinsurance	\$1,450
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,800</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	\$350
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

#### This EXAMPLE event includes services like:

Primary care physician visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,500</b>
---------------------------	----------------

In this example, Joe would pay:

Cost sharing	
Deductibles	\$350
Copayments	\$0
Coinsurance	\$1,030
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,380</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	\$350
■ <b>Specialist copayment</b>	\$35
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,500</b>
---------------------------	----------------

In this example, Mia would pay:

Cost sharing	
Deductibles	\$350
Copayments	\$0
Coinsurance	\$430
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$780</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact PEHP Healthy Utah, 801-366-7300.

The plan would be responsible for the other costs of these EXAMPLE covered services.

## SRP 2023-24 » Dental

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

### Preferred Dental Care

### Traditional Dental Care

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

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

\* AD = After Deductible

» If you choose this plan, you're not eligible to enroll in Preferred Choice, Traditional or Regence Expressions 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](http://www.pehp.org) or by calling PEHP).

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

# More Choices More Coverage

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

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

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

### Provisions/Limitations/Exclusions

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

# PEHP Full

## SUMMARY OF BENEFITS

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

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



### 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](http://eyemed.com/member) to see all plans included with your benefits.

# PEHP Eyewear Only

## SUMMARY OF BENEFITS

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



**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](http://eyemed.com/member) to see all plans included with your benefits.

# Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

## Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

## Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,<sup>1</sup> but our long list of special offers takes benefits even further.

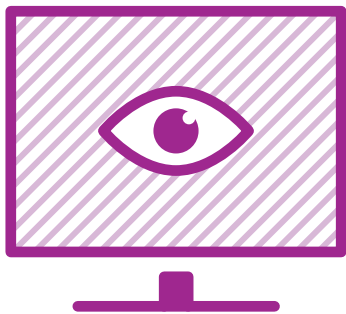
## Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

<sup>1</sup>Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.



eye  
Med



## Create a member account at [eyemed.com](https://eyemed.com)

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT  
PROVIDER  
NETWORK



LENSCRAFTERS

PEARLE  
EST. 1961  
VISION

OPTICAL



**OPTICARE PLAN – PEHP – Eye Exam & Hardware Benefits**  
 0-10-150/140C

Products/Services	Select Network	Broad Network	Out-Of-Network
<b>Eye Exam</b>			
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
<b>Standard Plastic Lenses</b>			
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	
<b>Lens Options</b>			
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	
<b>Coatings</b>			
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	
<b>Frames</b>			
Allowance Based on Retail Pricing	\$150 Allowance	\$130 Allowance	\$70 Allowance
<b>Additional Eyewear</b>			
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
<b>Contacts</b>			
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
<b>Frequency</b>			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
<b>Refractive Surgery</b>			
LASIK	20% Off Retail	Not Covered	Not Covered
<b>Dry Eye Treatments</b>			
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

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

Products/Services	Select Network	Broad Network	Out-Of-Network
<b>Standard Plastic Lenses</b>			
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	
<b>Lens Options</b>			
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	
<b>Coatings</b>			
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	
<b>Frames</b>			
Allowance Based on Retail Pricing	\$150 Allowance	\$130 Allowance	\$70 Allowance
<b>Additional Eyewear</b>			
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
<b>Contacts</b>			
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
<b>Frequency</b>			
Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
<b>Refractive Surgery</b>			
LASIK	20% Off Retail	Not Covered	Not Covered
<b>Dry Eye Treatments</b>			
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