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LGRP Selection & Participation Guidelines

Please review carefully

Medical

- If an agency offers multiple networks, it must select the same plan option for each network. Example: If you offer Advantage Traditional Option 1, you must offer Summit Traditional Option 1. Only one Preferred plan can be offered alongside Advantage, Capital and Summit plans.
- An agency can offer no more than six total plan and network combinations.
- The employer is required to contribute either 100% of the single premium or a minimum of 50% of the single, double, and family premiums. Medical plans require 80% participation of eligible employees.

Traditional Only or STAR HSA Only

Agencies with 9 subscribers* or less
- May offer only one medical plan and two networks.

Agencies with 10-50 subscribers
- May offer two medical plans and two networks.

Agencies with 51-99 subscribers
- May offer up to three medical plans and two networks.

Agencies with more than 99 subscribers
- May offer up to three medical plans and two networks.

STAR HSA and Traditional as Dual Option

Agencies with 9 subscribers or less
- Dual option is not available.

Agencies with 10-50 subscribers
- May offer one Traditional and one STAR HSA and two networks in the following combinations:
  - Traditional Option 1 with STAR HSA Option 1.
  - Traditional Option 2, 3, 4 or 5 with any STAR HSA Option.

Agencies with 51-99 subscribers
- May offer two Traditional and one STAR HSA and three networks.
  - Traditional Option 1 with STAR HSA Option 1.
  - Traditional Option 2, 3, 4 or 5 with any STAR HSA Option.

Agencies with more than 99 subscribers
- May offer two Traditional and one STAR HSA and three networks.
  - Traditional Option 1 with STAR HSA Option 1.
  - Traditional Option 2, 3, 4 or 5 with any STAR HSA Option.

Dental

- An agency may choose 2 of the 4 available dental plan designs.
- The Preferred plan includes a 5-year waiting period on missing tooth and a 6-month waiting period for new enrollees in need of major dental work. An agency may choose to eliminate both waiting periods at an additional cost to the plan. The Traditional, Premium, and Essential dental plans are offered without both waiting periods.
- The employer is required to contribute either 100% of the single premium or a minimum of 50% of the single, double, and family premiums. Medical plans require 80% participation of eligible employees.

Vision

- An agency may choose to offer up to four vision plans.
- The vision plans are completely voluntary.

** A subscriber is an employer's employee who has enrolled for coverage.*

Plan Summaries

Medical

- The LGRP offers five Traditional plan options and five HSA-qualified STAR HSA plan options.
- All LGRP plans are available on Preferred, Advantage, Capital, and Summit medical networks.
- All Traditional plans can be offered either with In-Network and Out-of-Network provider benefits or In-Network provider only benefits.
- The STAR HSA Plan options are only available with In-Network and Out-of-Network provider benefits.

Traditional	Deductible Individual / Family	Out-of-Pocket Individual / Family	Coinsurance Amount	Office co-pay Amount Primary / Specialist / Urgent
Option 1	$250 / $500	$3,000 / $6,000	90 / 10	$15 / $25 / $35
Option 2	$500 / $1,000	$4,000 / $8,000	80 / 20	$20 / $30 / $40
Option 3	$750 / $1,500	$5,000 / $10,000	80 / 20	$25 / $35 / $45
Option 4	$1,000 / $2,000	$6,000 / $12,000	80 / 20	$30 / $40 / $50
Option 5	$2,000 / $4,000	$6,000 / $12,000	80 / 20	$35 / $45 / $55

STAR HSA	Deductible Single / Family	Out-of-Pocket Single / Family	Coinsurance Amount	Office co-pay Amount Primary / Specialist / Urgent
Option 1	$1,500 / $3,000	$2,800 / $5,600	80 / 20	20% of In-Network Rate after deductible
Option 2	$1,500 / $3,000	$3,000 / $6,000	80 / 20	20% of In-Network Rate after deductible
Option 3	$2,000 / $4,000	$4,000 / $8,000	80 / 20	20% of In-Network Rate after deductible
Option 4	$2,500 / $5,000	$2,500 / $5,000	100	None
Option 5	$3,000 / $6,000	$6,000 / $12,000	80 / 20	20% of In-Network Rate after deductible

The table is for comparison purposes only.

Please refer to the medical benefits grid or renewal packet for more detailed benefit information.

PEHP Health & Benefits

Traditional Option 1

Summit, Advantage, Preferred, Capital

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: $250 Double/family plans: $250 per person, $500 per family *One person cannot meet more than $250*	
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/family plans: $3,000 per person, $6,000 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	30% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$15 co-pay per visit	30% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit	30% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	10% after deductible	30% after deductible
Emergency Room Specialist Visits	$25 co-pay per visit	$25 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	10% after deductible	30% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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	10% after deductible	30% after deductible
Urgent Care Facility	$35 co-pay per visit	30% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$125 co-pay after deductible per visit	$125 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	10% after deductible	30% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	10% after deductible	30% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	30% after deductible
Mental Health & Substance Abuse	10% after deductible	30% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	10% after deductible	30% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	10% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	10% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	10% after deductible	30% after deductible
Chiropractic care | *Up to 20 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	30% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	30% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge	30% after deductible
Hospice	No charge	30% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible	30% after deductible
Infertility Services | *Select services only. See Master Policy for details*	10% after deductible	30% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	10% after deductible	30% after deductible

PEHP Health & Benefits

Traditional Option 2

Summit, Advantage, Preferred, Capital

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: $500 Double/family plans: $500 per person, $1,000 per family *One person cannot meet more than $500*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $4,000 Double/family plans: $4,000 per person, $8,000 per family *One person cannot meet more than $4,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$20 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$30 co-pay per visit	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$30 co-pay per visit	$30 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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	$40 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	No charge	40% after deductible
Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 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

PEHP Health & Benefits

Traditional Option 3

Summit, Advantage, Preferred, Capital

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: $750 Double/family plans: $750 per person, $1,500 per family *One person cannot meet more than $750*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $5,000 Double/family plans: $5,000 per person, $10,000 per family *One person cannot meet more than $5,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
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 – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	$45 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$175 co-pay after deductible per visit	$175 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	No charge	40% after deductible
Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 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

PEHP Health & Benefits

Traditional Option 4

Summit, Advantage, Preferred, Capital

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: $1,000 Double/family plans: $1,000 per person, $2,000 per family *One person cannot meet more than $1,000*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $6,000 Double/family plans: $6,000 per person, $12,000 per family *One person cannot meet more than $6,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$30 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$40 co-pay per visit	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$40 co-pay per visit	$40 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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	$50 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$200 co-pay after deductible per visit	$200 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	No charge	40% after deductible
Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 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

PEHP Health & Benefits

Traditional Option 5

Summit, Advantage, Preferred, Capital

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: $2,000 Double/family plans: $2,000 per person, $4,000 per family *One person cannot meet more than $2,000*	
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $6,000 Double/family plans: $6,000 per person, $12,000 per family *One person cannot meet more than $6,000*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$45 co-pay per visit	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	$45 co-pay per visit	$45 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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	$55 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$225 co-pay after deductible per visit	$225 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit	Not applicable
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge	40% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	40% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	No charge	40% after deductible
Hospice	No charge	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 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

PEHP Health & Benefits

Traditional Option 1

Summit, Advantage, Preferred, Capital

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
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $250 Double/family plans: $250 per person, $500 per family *One person cannot meet more than $250*
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/family plans: $3,000 per person, $6,000 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
PEHP VALUE PROVIDERS	
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit
PROFESSIONAL SERVICES	
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$15 co-pay per visit
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit
Surgery and Anesthesia	10% after deductible
Emergency Room Specialist Visits	$25 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	10% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24

	In-Network Provider
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
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
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
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	10% after deductible
Urgent Care Facility	$35 co-pay per visit
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$125 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	10% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	10% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit
Mental Health & Substance Abuse	10% after deductible
INPATIENT FACILITY SERVICES	
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	10% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	10% after deductible

	In-Network Provider
MISCELLANEOUS SERVICES	
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization.* *Excludes multiple-embryo ART implants*	10% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant
Allergy Serum	10% after deductible
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit
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
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge
Hospice	No charge
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services | *Select services only. See Master Policy for details*	10% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	10% after deductible

PEHP Health & Benefits

Traditional Option 2

Summit, Advantage, Preferred, Capital

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
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $500 Double/family plans: $500 per person, $1,000 per family *One person cannot meet more than $500*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $4,000 Double/family plans: $4,000 per person, $8,000 per family *One person cannot meet more than $4,000*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PEHP VALUE PROVIDERS	
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit
PROFESSIONAL SERVICES	
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$20 co-pay per visit
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$30 co-pay per visit
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$30 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24

	In-Network Provider
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
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
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
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	20% after deductible
Urgent Care Facility	$40 co-pay per visit
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit
Mental Health & Substance Abuse	20% after deductible
INPATIENT FACILITY SERVICES	
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible

	In-Network Provider
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
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit
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
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge
Hospice	No charge
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible

PEHP Health & Benefits

Traditional Option 3

Summit, Advantage, Preferred, Capital

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
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $750 Double/family plans: $750 per person, $1,500 per family *One person cannot meet more than $750*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $5,000 Double/family plans: $5,000 per person, $10,000 per family *One person cannot meet more than $5,000*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PEHP VALUE PROVIDERS	
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit
PROFESSIONAL SERVICES	
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$25 co-pay per visit
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24

	In-Network Provider
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
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
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
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	20% after deductible
Urgent Care Facility	$45 co-pay per visit
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$175 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit
Mental Health & Substance Abuse	20% after deductible
INPATIENT FACILITY SERVICES	
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible

	In-Network Provider
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
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit
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
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge
Hospice	No charge
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible

PEHP Health & Benefits

Traditional Option 4

Summit, Advantage, Preferred, Capital

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
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,000 Double/family plans: $1,000 per person, $2,000 per family *One person cannot meet more than $1,000*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $6,000 Double/family plans: $6,000 per person, $12,000 per family *One person cannot meet more than $6,000*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PEHP VALUE PROVIDERS	
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit
PROFESSIONAL SERVICES	
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$30 co-pay per visit
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$40 co-pay per visit
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$40 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24

	In-Network Provider
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
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
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
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	20% after deductible
Urgent Care Facility	$50 co-pay per visit
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$200 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit
Mental Health & Substance Abuse	20% after deductible
INPATIENT FACILITY SERVICES	
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible

	In-Network Provider
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
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit
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
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge
Hospice	No charge
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible

PEHP Health & Benefits

Traditional Option 5

Summit, Advantage, Preferred, Capital

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
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS	
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,000 Double/family plans: $2,000 per person, $4,000 per family *One person cannot meet more than $2,000*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $6,000 Double/family plans: $6,000 per person, $12,000 per family *One person cannot meet more than $6,000*
ANNUAL PREVENTIVE CARE	
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge
PEHP VALUE PROVIDERS	
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit
PROFESSIONAL SERVICES	
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	$35 co-pay per visit
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	$45 co-pay per visit
University of Utah Medical Group (UUMG) | *Preferred plans only*	$50 co-pay per visit
Surgery and Anesthesia	20% after deductible
Emergency Room Specialist Visits	$45 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***	
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24

	In-Network Provider
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
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
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
OUTPATIENT FACILITY SERVICES	
Outpatient Facility and Ambulatory Surgical Center	20% after deductible
Urgent Care Facility	$55 co-pay per visit
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$225 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	$50 co-pay per visit
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	Applicable co-pay per visit
Mental Health & Substance Abuse	20% after deductible
INPATIENT FACILITY SERVICES	
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible

	In-Network Provider
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
Chiropractic care | *Up to 20 visits per plan year*	Applicable office co-pay per visit
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
Medical Supplies *See Master Policy for benefit limits*	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge
Hospice	No charge
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge **Over $50:** 20% after deductible
Infertility Services | *Select services only. See Master Policy for details*	20% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum. See Master Policy for details*	20% after deductible

PEHP Health & Benefits

STAR HSA Option 1

Summit, Advantage, Preferred, Capital

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: $2,800 Double/family plans: $5,600 *One person or a combination can meet the $5,600 double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	20% after deductible	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Health & Benefits

STAR HSA Option 2

Summit, Advantage, Preferred, Capital

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: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $6,000 double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	20% after deductible	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	20% after deductible	Not applicable
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		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Health & Benefits

STAR HSA Option 3

Summit, Advantage, Preferred, Capital

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: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $4,000 Double/family plans: $8,000 *One person or a combination can meet the $8,000 double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	20% after deductible	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	20% after deductible	Not applicable
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		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Health & Benefits

STAR HSA Option 4

Summit, Advantage, Preferred, Capital

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: $2,500 Double/family plans: $5,000 *One person or a combination can meet the $5,000 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $2,500 Double/family plans: $5,000 *One person or a combination can meet the $5,000 double/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	20% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	No charge after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	No charge after deductible	20% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	No charge after deductible	20% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	No charge after deductible	Not applicable
Surgery and Anesthesia	No charge after deductible	20% after deductible
Emergency Room Specialist Visits	No charge after deductible	No charge after deductible
Diagnostic Tests, Labs, X-rays	No charge after deductible	20% 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*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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:** No charge **Tier B:** No charge	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:** No charge **Tier B:** No charge	**Tier A:** 20%. No maximum co-pay **Tier B:** 20%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** No charge **Tier B:** No charge **Tier C1:** No charge **Tier C2:** No charge **Tier C3:** No charge	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	No charge after deductible	20% after deductible
Urgent Care Facility	No charge after deductible	20% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	No charge after deductible	No charge after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	No charge after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	No charge after deductible	Not applicable
Diagnostic Tests, Labs, X-rays	No charge after deductible	20% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	No charge after deductible	20% after deductible
Physical and Occupational Therapy *Outpatient – Up to 20 combined visits per plan year.*	No charge after deductible	20% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	No charge after deductible	20% after deductible
INPATIENT FACILITY SERVICES		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	No charge after deductible	20% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	No charge after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	No charge after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	No charge after deductible	20% after deductible
Chiropractic care | *Up to 20 visits per plan year*	No charge after deductible	Not covered
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list. See Master Policy for benefit limits*	No charge after deductible Summit Network: Alpine Home Medical	20% after deductible
Medical Supplies *See Master Policy for benefit limits*	No charge after deductible	20% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge after deductible	20% after deductible
Hospice	No charge after deductible	20% after deductible
Injections *Includes allergy injections. See above for allergy serum*	No charge after deductible	20% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	No charge after deductible	20% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	No charge after deductible	20% after deductible

PEHP Health & Benefits

STAR HSA Option 5

Summit, Advantage, Preferred, Capital

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $3,000 Double/family plans: $6,000 *One person or a combination can meet the $6,000 double/family deductible*	
Plan year Out-of-Pocket Maximum *Any one idividual may not apply more than $8,700 toward the In-Network family Out-of-Pocket Maximum*	Single plans: $6,000 Double/family plans: $12,000 *One person can only meet $8,700, or a combination can meet the $12,000 double/family maximum*	
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	40% after deductible
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Primary Care Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes office surgeries, inpatient visits and Autism services*	20% after deductible	40% after deductible
University of Utah Medical Group (UUMG) | *Preferred plans only*	20% after deductible	Not applicable
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	See Pharmacy options for 2023-24	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	See Pharmacy options for 2023-24	Not covered

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | *All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org*		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 50%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
University of Utah Medical Group (UUMG) Urgent Care *Preferred plans only*	20% after deductible	Not applicable
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		
Hospital Services ***Medical, Surgical, Mental Health, Substance Abuse and Rehabilitation*** *All out-of-network facilities and some in-network facilities require preauthorization. See Master Policy for details. Rehabilitation up to 45 days per plan year and requires preauthorization*	20% after deductible	40% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption / Assisted Reproductive Technology (ART) *See Master Policy for benefit limits. ART requires Preauthorization. Excludes multiple-embryo ART implants*	20% after deductible, up to $4,000 per adoption or up to $4,000 per single-embryo ART implant	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 20 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. Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

PEHP Medical Networks

Find Participating Providers at www.pehp.org

PEHP Advantage

36 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Intermountain Health (IH) 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
Spanish Fork Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

Weber County
McKay-Dee Hospital

PEHP Summit

40 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 Medical Center

Weber County
Ogden Regional Medical Center

PEHP Capital

33 PARTICIPATING HOSPITALS, 7,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Steward Health, 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

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Huntsman Cancer Hospital
Jordan Valley Hospital
Jordan Valley Hospital - West
Primary Children's Medical Center
Riverton Children's Unit
Salt Lake Regional Medical Center

Salt Lake County (cont)
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 Point Medical Center

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

PEHP Preferred

52 PARTICIPATING HOSPITALS, 12,000+ PARTICIPATING PROVIDERS

Network consists of providers and facilities in both the Advantage and Summit networks.

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	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**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	**40%** of In-Network Rate

Note: Six month waiting period applies to prosthodontic, implant, and orthodontics benefits unless you show PEHP you were covered by a qualified dental insurance plan for at least six consecutive months before joining PEHP dental.

PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All eligible related services	**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	
Eligible Appliances and Procedures	**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.

For dental services covered by PEHP medical plans, there is no dental plan coverage.

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	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**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	**40%** of In-Network Rate
PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All eligible related services	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum	

For dental services covered by PEHP medical plans, there is no dental plan coverage.

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.

Traditional Dental Care	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
Annual Benefit Max	**$1,500** per person	**$1,500** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**$0**	**20%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**$0**	**20%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate AD*	**40%** of In-Network Rate AD
Composite Restoration	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD
Root Canal	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD
PERIODONTICS		
	20% of In-Network Rate AD	**40%** of In-Network Rate AD
ORAL SURGERY		
Extractions	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD
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
PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Bridges	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Dentures (partial)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Dentures (full)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
IMPLANTS		
All eligible related services	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
ORTHODONTIC BENEFITS		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum AD	

***** = After Deductible

For dental services covered by PEHP medical plans, there is no dental plan coverage.

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.

Premium Dental Care	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$2,000** per person	**$2,000** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**$0**	**20%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**$0**	**20%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**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	**40%** of In-Network Rate
PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All eligible related services	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum	

For dental services covered by PEHP medical plans, there is no dental plan coverage.

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.

Essential Dental Care	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
Annual Benefit Max	**$1,000** per person	**$1,000** per person
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**$0**	**20%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**$0**	**20%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**30%** of In-Network Rate AD*	**50%** of In-Network Rate AD
Composite Restoration	**30%** of In-Network Rate AD	**50%** of In-Network Rate AD
ENDODONTICS		
Pulpotomy	**30%** of In-Network Rate AD	**50%** of In-Network Rate AD
Root Canal	**30%** of In-Network Rate AD	**50%** of In-Network Rate AD
PERIODONTICS		
	30% of In-Network Rate AD	**50%** of In-Network Rate AD
ORAL SURGERY		
Extractions	**30%** of In-Network Rate AD	**50%** of In-Network Rate AD
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	**30%** of In-Network Rate AD	**50%** of In-Network Rate AD
PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Bridges	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Dentures (partial)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
Dentures (full)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
IMPLANTS		
All eligible related services	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
ORTHODONTIC BENEFITS		
Maximum Lifetime Benefit per Member	**$1,500 –** Does not apply to the Annual Benefit Maximum	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum	

***** = After Deductible

For dental services covered by PEHP medical plans, there is no dental plan coverage.

PEHP Contact Information

ON THE WEB

» PEHP website.....www.pehp.org

Log in to your online personal account for personal health and plan benefit information. You can review your claims history, see a comprehensive list of your coverages, look up contracted providers, check your FLEX$ account, and more. Create an account to enroll in PEHP benefits electronically.

CUSTOMER SERVICE

.....801-366-7555
..... or 800-765-7347

Weekdays from 8 a.m. to 5 p.m.
Have your PEHP ID or Social Security number on hand for faster service. Foreign language assistance available.

PRE-NOTIFICATION/PRE-AUTHORIZATION

» Inpatient Hospital Pre-authentification 801-366-7755
..... or 800-753-7754

MENTAL HEALTH/SUBSTANCE ABUSE PRE-AUTHORIZATION

» PEHP Customer Service.....801-366-7555
.....or 800-765-7347

GROUP TERM LIFE AND AD&D

» PEHP Life and AD&D.....801-366-7495

PEHP FLEX$

» PEHP FLEX$ Department 801-366-7503
..... or 800-753-7703

PRENATAL PROGRAM

» PEHP WeeCare.....801-366-7400
..... or 855-366-7400
.....www.pehp.org/weecare

PRESCRIPTION DRUG BENEFITS

» PEHP Customer Service.....801-366-7555
..... or 800-765-7347

» Express Scripts.....800-903-4725
..... www.express-scripts.com

SPECIALTY PHARMACY

» Accredo 800-501-7260

WELLNESS AND DISEASE MANAGEMENT

» PEHP Healthy Utah 801-366-7300
..... or 855-366-7300
.....www.pehp.org

» PEHP Health Coaching.....801-366-7300
..... or 855-366-7300
.....www.pehp.org

» PEHP Integrated Care.....801-366-7555
..... or 800-765-7347

VALUE-ADDED BENEFITS PROGRAM

» PEHPplus.....www.pehp.org/plus

CLAIMS MAILING ADDRESS

PEHP
560 East 200 South
Salt Lake City, Utah 84102-2004

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

Local Governments
Enrollment and Change Form

Employee Status ☐ Full time ☐ Part time
Benefit Eligibility ☐ Eligible ☐ Ineligible

Note: *Changes made on this form are for medical, dental and vision only. All other changes can be made online at www.pehp.org.* ***Please print clearly.***

☐ New Enrollment ☐ Termination ☐ 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	HIRE DATE (mm/dd/yy)	

Group Medical (check one) | **Check with your employer to see what options are available to you**

Medical Plans Using In-network & and Out-of-network Providers

Summit Network

☐ The STAR HSA Plan Option **1*** ☐ Traditional Option **1**
☐ The STAR HSA Plan Option **2*** ☐ Traditional Option **2**
☐ The STAR HSA Plan Option **3*** ☐ Traditional Option **3**
☐ The STAR HSA Plan Option **4*** ☐ Traditional Option **4**
☐ The STAR HSA Plan Option **5*** ☐ Traditional Option **5**

☐ * I'm eligible for a Health Savings Account (HSA)
☐ * I'm not eligible for an HSA

Advantage Network

☐ The STAR HSA Plan Option **1*** ☐ Traditional Option **1**
☐ The STAR HSA Plan Option **2*** ☐ Traditional Option **2**
☐ The STAR HSA Plan Option **3*** ☐ Traditional Option **3**
☐ The STAR HSA Plan Option **4*** ☐ Traditional Option **4**
☐ The STAR HSA Plan Option **5*** ☐ Traditional Option **5**

☐ * I'm eligible for a Health Savings Account (HSA)
☐ * I'm not eligible for an HSA

Preferred Network

☐ The STAR HSA Plan Option **1*** ☐ Traditional Option **1**
☐ The STAR HSA Plan Option **2*** ☐ Traditional Option **2**
☐ The STAR HSA Plan Option **3*** ☐ Traditional Option **3**
☐ The STAR HSA Plan Option **4*** ☐ Traditional Option **4**
☐ The STAR HSA Plan Option **5*** ☐ Traditional Option **5**

☐ * I'm eligible for a Health Savings Account (HSA)
☐ * I'm not eligible for an HSA

Capital Network

☐ The STAR HSA Plan Option **1*** ☐ Traditional Option **1**
☐ The STAR HSA Plan Option **2*** ☐ Traditional Option **2**
☐ The STAR HSA Plan Option **3*** ☐ Traditional Option **3**
☐ The STAR HSA Plan Option **4*** ☐ Traditional Option **4**
☐ The STAR HSA Plan Option **5*** ☐ Traditional Option **5**

☐ * I'm eligible for a Health Savings Account (HSA)
☐ * I'm not eligible for an HSA

Medical Plans Using In-network Providers Only

Summit Network	Advantage Network	Preferred Network	Capital Network
☐ Option **1**	☐ Option **1**	☐ Option **1**	☐ Option **1**
☐ Option **2**	☐ Option **2**	☐ Option **2**	☐ Option **2**
☐ Option **3**	☐ Option **3**	☐ Option **3**	☐ Option **3**
☐ Option **4**	☐ Option **4**	☐ Option **4**	☐ Option **4**
☐ Option **5**	☐ Option **5**	☐ Option **5**	☐ Option **5**

Medical coverage type (Check one)
☐ EMPLOYEE ONLY
☐ Employee plus one dependent
☐ Employee plus two or more dependents
☐ No medical coverage at this time

GROUP DENTAL (Check one)
☐ Preferred Dental Care
☐ Traditional Dental Care
☐ Premium Dental Care
☐ Essential Dental Care
☐ No dental coverage at this time

Dental coverage type (Check one)
☐ EMPLOYEE ONLY
☐ Employee plus one dependent
☐ Employee plus two or more dependents

VISION (Check one)
☐ Eyemed – Full
☐ Eyemed – Eyewear Only
☐ Opticare – Full
☐ Opticare – Eyewear Only
☐ No vision coverage at this time

Vision coverage type (Check one)
☐ EMPLOYEE ONLY
☐ Employee plus one dependent
☐ Employee plus two or more dependents

ADDITIONS List your eligible dependents. If adding a new spouse, include a copy of marriage certificate. If dependents are stepchildren, natural children not living with both parents, or "other" relationship, provide supporting documentation, e.g., divorce decree, court orders, birth certificate, etc. If you don't have supporting documentation explain in Explanations Section on the back.

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
CODE KEY: **S** » Legal Spouse; **C** » Child Natural/ Adopted; **SC** » Stepchild; **O** » Other (Describe in Explanations)	**S**			☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision

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.**

Signature required on other side.

(Employer use only) **LG-PE 09-15-20**

Effective Date:_____ Employment Termination Date:_____ Coverage Termination Date:_____ Employer Approval:_____

Page 2: Local Governments | Enrollment and Change Form

Employee Name: _____ Social Security Number: _____

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
S » Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Explanations)						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision
						☐**M**edical ☐**D**ental ☐**V**ision

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

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/DEPENDENTS 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

Please make a copy for your records.

PEHP Full

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)
- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

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

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

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

PREMIUMS - monthly	
Subscriber only	$7.51
Subscriber + 1	$12.07
Subscriber + family	$16.60

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

PEHP Eyewear Only

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

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

Heads up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

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

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

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

PREMIUMS - monthly	
Subscriber only	$6.53
Subscriber + 1	$10.18
Subscriber + family	$13.83

HOW TO: mobilize your vision plan

EYEMED MEMBERS APP

Our member app was the first of its kind. But innovation – like your life – never stops. The EyeMed Members App is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed Members App:

1. **DOWNLOAD** – Search "EyeMed Members" in your App store, iTunes or Google Play.
2. **OPEN** – You can use some features right away; others unlock once you register.
3. **REGISTER** – You'll need your member ID or the last four digits of your social security number.
4. **LOG IN** – If you've already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	●	
On-the-fly appointment scheduling	●	
Turn by turn directions and map	●	
Eye exam and contact lens reminders		●
Electronic ID card for office visits		●
Save vision prescriptions*		●
Benefit plan details		●
Answers to common questions	●	
Special offers and discounts		●
Direct line to EyeMed support	●	

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

** Take a picture of your prescription and store it in your app. No need to type in the numbers.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL

PDF-1801-M-135

Plan	Monthly Rate
Single	$8.31
2-Party	$12.42
Family	$17.70

OPTICARE PLAN – PEHP – Eye Exam & Hardware Benefits

0-10-150/140C

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

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

Plan	Monthly Rate
Single	$6.45
2-Party	$9.49
Family	$12.82

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

OpticareVision™

Register and **Print Member ID Cards Online**

Printing member ID cards is simple! This guide will walk you through each step of the process.

1 Access the member portal

1a Go to **www.opticarevisionservices.com**

1b Click the "MEMBERS" link in the left navigation

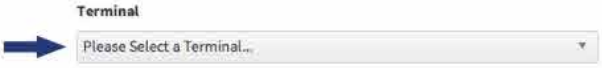
1c Click the "MANAGE YOUR ACCOUNT" banner

2 Register as a new user

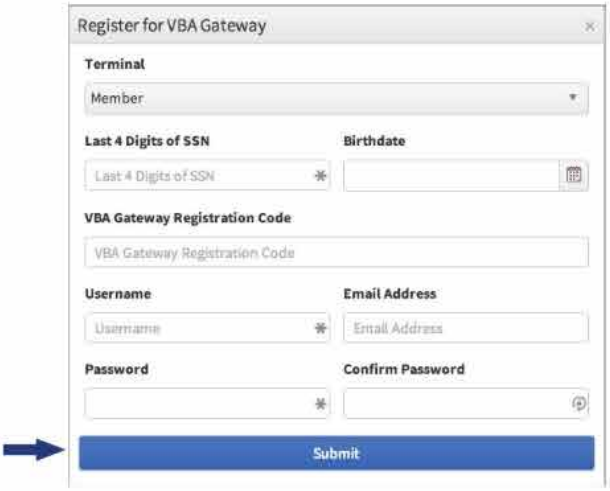
*If you have already registered, skip to step 3.
*Have your gateway registration code ready. *(This is your full Member ID - Please contact us if you need this for your initial registration - 1-800-363-0950)*

2a Click on "Click here to register"

2b Click the drop down menu, select "Member"



2c Fill out the form with the necessary details, then click the "Submit" button



3 Obtain ID Cards

3a Log into your account

3b Hover over the menu icon, select "Print Temp. ID Card"

3c Print Temporary ID Card. Scoll down and click "Print"

OpticareVision

PROVIDER LOCATER Tool

Over 30,000 Access Points at Your Fingertips.

Visit **www.opticarevisionservices.com**
Click on Menu then **"LOCATE A PROVIDER"**

From "**LOCATE A PROVIDER**" page

Select "**IN-NETWORK**" to search for any contracted provider, anywhere in the US. ENTER ZIP CODE and your providers will be on the screen in order of distance based on the zip code you entered.

Select "**STANDARD OPTICAL"** for a listing of all Standard Optical locations. Note - All plans have access to Standard Optical locations, however these are only available in Utah. You can schedule your appointment for these locations on the website.

Select "**OUT-OF-NETWORK**" to submit a claim for out-of-network reimbursement. You can download a claim form or fill out electronically for submission. Note - not all plans have out-of-network benefits. Please refer to your plan documents.

Member Services: 801-869-2029
Schedule an Eye Exam: 385-270-8200

OpticareVision

2023-24 LGRP Pharmacy Options

» Pharmacy options are now available on your agency's rate sheet.

» Contact your PEHP Client Services Representative for more information.

» **Specialty Drug Rates:** For benefit information regarding specialty drugs on the below pharmacy selections, please refer to the 2023-24 LGRP medical benefits grids.

OPTION	A	B	C	D	G
Retail (30-day supply)					
Tier 1	$10 co-pay	$10 co-pay	$15 co-pay	$10 co-pay	10% of discounted cost, $7 min./no max.
Tier 2	25% of discounted cost, $25 min./$75 max.	$25 co-pay	$30 co-pay	25% of discounted cost, $25 min./no max.	25% of discounted cost, $40 min./no max.
Tier 3	50% of discounted cost, $50 min./$100 max.	$50 co-pay	$65 co-pay	50% of discounted cost, $50 min./no max.	50% of discounted cost, $70 min./no max.
Home Delivery (90-day supply) *Some medications available through retail pharmacy at mail-order co-pay*					
Tier 1	$20 co-pay	$20 co-pay	$30 co-pay	$20 co-pay	10% of discounted cost, $17 min./no max.
Tier 2	25% of discounted cost, $50 min./$150 max.	$50 co-pay	$60 co-pay	25% of discounted cost, $50 min. / no max.	25% of discounted cost, $100 min. / no max.
Tier 3	50% of discounted cost, $100 min./$200 max.	$100 co-pay	$130 co-pay	50% of discounted cost, $100 min./no max.	50% of discounted cost, $175 min./no max.

** A subscriber is an employer's employee who has enrolled for coverage.*

Expanded Preventive **Medications**

The STAR HSA Plan

Expanded preventive drug coverage means that PEHP will pay a portion of the drug cost for some STAR HSA plans even before you meet your deductible. **Check your benefit summary for plan coverage details as not all STAR HSA plans include this benefit.** Make sure to visit an in-network pharmacy to receive this benefit.

Diabetes

GLUCOSE RESCUE PRODUCTS
GlucaGen HypoKit
Glucagon
INSULINS
Novolog vials
Novolin vials
Lantus vials
METFORMIN PRODUCTS
glipizide-metformin
glyburide-metformin
metformin
metformin ER (non OSM, non MOD)
MISCELLANEOUS
pioglitazone
TESTING SUPPLIES
Freestyle test strips
SULFONYLUREAS
glimepiride
glipizide
glipizide ER
glyburide
glyburide micronized
tolazamide

Depression

citalopram
escitalopram
fluoxetine
sertraline

Cardiovascular

ANTICOAGULANTS/ ANTIPLATELETS
clopidogrel
dipyridamole
warfarin
BETA BLOCKERS
acebutolol
bisoprolol
carvedilol
labetalol
metoprolol succinate
metoprolol tartrate
propranolol solution
propranolol tablets
sotalol
timolol maleate tablets
CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem
felodipine ER
isradipine
nifedipine tablets ER
verapamil
COMBINATION PRODUCTS
amiloride & HCTZ
atenolol & chlorthalidone
bisoprolol & HCTZ
enalapril & HCTZ
irbesartan & HCTZ
lisinopril & HCTZ
losartan & HCTZ
metoprolol & HCTZ
nadolol & bendroflumethiazide
propranolol & HCTZ
triamterene & HCTZ

RENIN/ANGIOTENSIN SYSTEM ANTAGONIST (ACEI/ARB)
enalapril
fosinopril
irbesartan
lisinopril
losartan
quinapril
ramipril
trandolapril
DIURETICS
amiloride
bumetanide
chlorothiazide
chlorthalidone
furosemide solution
furosemide tablets
hydrochlorothiazide capsules
hydrochlorothiazide tablets
indapamide
methazolamide
methyclothiazide
spironolactone
torsemide
MISCELLANEOUS
prazosin
clonidine
digoxin
VASODILATORS
hydralazine
isosorbide

Respiratory

ANTICHOLENERGICS
ipratropium bromide solution
INHALED CORTICOSTEROIDS
QVAR inhaler
SABA/ ANTICHOLENERGICS
ipratropium-albuterol inhaler
ipratropium-albuterol nebulized
SHORT ACTING BETA AGONISTS
albuterol ER tablets
albuterol nebulized
albuterol syrup
albuterol tablets
ProAir HFA inhaler
ProAir RespiClick
Ventolin inhaler

Osteoporosis

alendronate

PEHP Health & Benefits

12-14-21

PEHP FLEX$ Plan Year: July 1, 2023 – June 30, 2024

FLEX$ saves you money by reducing your taxable income. You set aside a portion of your pre-tax salary to pay eligible expenses.

PEHP offers two types of FLEX$: healthcare and dependent day care. Enroll in one or both.

ENROLLMENT

» You must re-enroll for FLEX$ every plan year.

» **Open enrollment**: Enroll online at www.pehp.org. Or fill out a paper form and return it to PEHP (fax: 801-366-7772).

» **New hires:** Enroll within 60 days of eligibility date.

PLAN YEAR CONTRIBUTION LIMITS

» Up to **$3,050** for healthcare expenses (May adjust annually for inflation).

» Up to **$5,000** for dependent day care expenses (you and your spouse combined).

HOW YOU CONTRIBUTE

» Your contributions are withheld from your paycheck pre-tax. The total amount you contribute is evenly divided among pay periods.

» The total amount you choose to withhold for healthcare expenses is immediately available as soon as you begin FLEX$.

YOU CAN'T HAVE AN HSA WITH FLEX$

You can't contribute to a health savings account (HSA) while you're enrolled in healthcare FLEX$. However, you may have a dependent day care FLEX$ and/or a limited FSA and contribute to an HSA.

OLDER CHILDREN

» Children up to age 26* can remain covered regardless of marital or dependent status.

*(*Up to Dec. 31 of the calendar year they turn age 26.)*

Reminder

You can carry over up to $610 in your healthcare FLEX$ from one plan year to the next. You do not have a grace period for eligible expenses.

FLEX$ Timeline

PLAN YEAR:
July 1, 2023 – June 30, 2024

Eligible FLEX$ expenses must be incurred between July 1, 2023 and June 30, 2024.

You must submit claims by September 30, 2024.

July 1, 2023

2023-24 FLEX$ plan year begins

June 30, 2024

2023-24 FLEX$ plan year ends

September 30, 2024

Deadline to submit claims

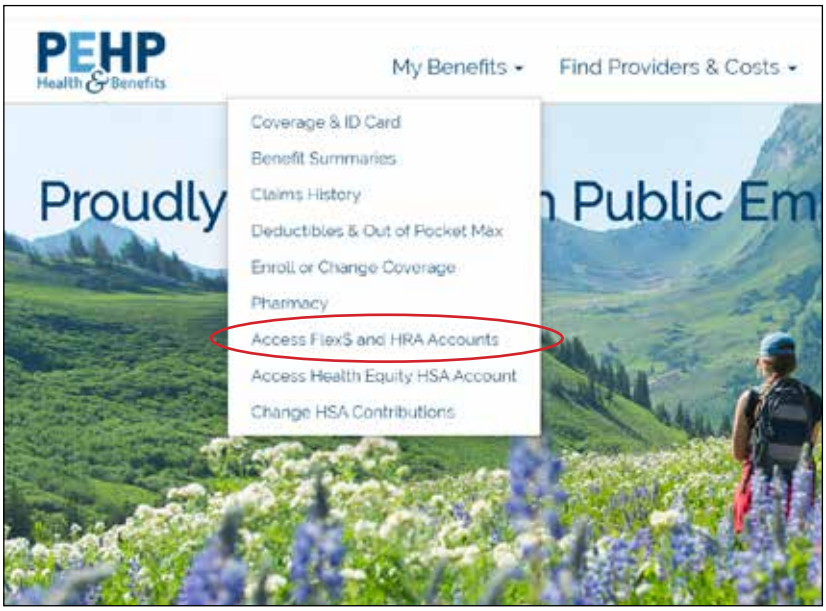
After September 30, 2024

You can carry over up to $610 in your healthcare FLEX$ into the next plan year

PEHP FLEX$ Plan Year: July 1, 2023 – June 30, 2024

Managing FLEX$ Online

Visit www.pehp.org, hover over the "My Benefits" menu header, and select "Access Flex$ and HRA accounts."



Using Your FLEX$ Card

Access your FLEX$ account with the FLEX$ Benefits Card you will automatically receive at no extra cost. It can work just like a credit card or a debit card. The FLEX$ card does not work for Day Care accounts.

The FLEX$ card doesn't always distinguish which purchases are eligible. You're responsible to keep all receipts for tax and verification purposes. PEHP may ask for verification of charges.

For places that don't accept the FLEX$ Benefits Card, simply pay for the charges and submit a copy of the detailed receipt and a claim form to PEHP for reimbursement.

Limitations apply. Go to www.pehp.org for eligibility and more details.

Eligible Expenses

» Most over-the-counter drugs and medicines can be paid for or reimbursed without a doctor's prescription.

» Menstrual care products are now considered a qualified medical expense and are eligible for payment or reimbursement.

FLEX$ HEALTHCARE ACCOUNT for eligible health expenses for you and your eligible dependents. A partial list of eligible expenses is on the back of this brochure.

FLEX$ DEPENDENT DAY CARE ACCOUNT for eligible day care expenses for your eligible dependents to allow you and/or your spouse to work, look for work, or go to school.

For more information about which expenses are eligible, download IRS Publication 502.

PEHP FLEX$ Plan Year: July 1, 2023 – June 30, 2024

What's covered?

Examples of eligible expenses

» Alcohol & drug treatment programs
» Band-Aids, bandages & gauze pads
» Body scan – diagnostic or screening tests
» Cold/hot packs for injuries
» Cold, flu medicine, cough drops & throat lozenges
» Condoms & spermicidal foam
» Contact lenses, including lens care supplies
» Eyeglasses
» First aid cream & antibacterial ointment
» Hand sanitizer
» Hearing aids & batteries
» Infertility treatment
» Laser eye surgery
» Masks (PPE)
» Menstrual care products
» Orthodontia (copy of contract required)
» Orthotics
» Most over-the-counter medications
» Prescription drugs
» Routine physical exams
» Nasal strips
» Sanitizing wipes
» Sunburn ointment or cream
» Thermometers

What's not covered?

Examples of non-eligible expenses

» Aromatherapy
» Botox
» Contact lens service agreement or insurance
» Cosmetic procedures & surgery
» Dental service agreement
» Face cream, suntan lotion & moisturizers
» Health club dues and gym memberships
» Insurance premiums
» Electrolysis or hair removal
» Oral supplies and electric toothbrushes
» Payments for services performed outside the current plan year
» Vitamins and supplements

Examples of expenses requiring a doctor's note

» Massage therapy
» Sunglasses
» Weight loss drugs & programs for treatment of a specific disease

PEHP FLEX$ CONTACT INFO

Phone: 801-366-7503 or 800-753-7703 | **Fax:** 801-366-7772 | **Email:** flex@pehp.org

3-9-22

PEHP LTD

Your Reliable Safety Net

PEHP Long-Term Disability (LTD) is your safety net should you become disabled and unable to work. This important benefit is paid for by your employer at no cost to you.

After a three-month waiting period, LTD provides two-thirds of your regular monthly salary for accidental bodily injury, disease, or illness if you're unable to perform your regular job. If you're disabled by external force or violence while performing your job, you may be eligible to receive 100% of your regular salary.

After two years on LTD, if you can't perform any gainful employment, you may apply for "ongoing" LTD. To continue receiving the benefit, you must be unable to perform any gainful employment.

LTD Basics	
Benefit Amount	Two-thirds of your salary
Waiting Period	Three months; closest to the first of the month
First 24 months of LTD	Must be unable to perform your regular job
After 24 months of LTD	Must be unable to perform any gainful employment (includes sedentary work)
Maximum Benefit	Age 65* or retirement with Utah Retirement Systems**
Line of Duty Benefit (External Force/Violence)	100% of regular salary

*Exception is if date of disability is age 60+. See Page 4.

**Go to www.urs.org to find out the years of service required for you to retire.

Learn More About PEHP LTD

Answers to our most frequently asked questions

When should I apply for LTD benefits?
You must apply for LTD benefits within six months from your last day worked in your regular full-duty job.

We encourage you to apply as soon as possible.

How do I apply for LTD benefits?
Contact our office for a phone interview and then you will be mailed an application and other forms to sign. See contact information on the back page.

Who is eligible?
Most employees who are eligible for an employer sponsored retirement plan are eligible for LTD; contact us if you need to confirm your eligibility. The Legislature created the benefit as a bridge from active to retirement status therefore URS post-retirees are ineligible. Retirement is the only benefit available to employees who have accrued full years of service toward retirement because Title 49 states LTD benefits terminate when the eligible employee has accumulated the following years:

Accrued years to retire are:
- Tier 1 Public Employee: 30 years
- Tier 1 Public Safety: 20 years
- Tier 2 Public Employee: 35 years
- Tier 2 Public Safety: 25 years

It is also important to note that age is not a factor in determining initial eligibility; if you're age 60 or older, see page 4.

Vocational Rehabilitation	Services include counseling and assistance returning to your regular job or finding new employment.
Rehabilitative Employment	May be able to work while on LTD. Requires prior approval. LTD benefits partially reduced.

How does PEHP LTD confirm I am disabled?
We must confirm your disability and impairment with objective medical documentation. We do this by collecting and reviewing medical records from your healthcare providers.

What happens to my URS retirement accrual while I am on LTD?

- **If you were hired before July 1, 2011**, you will continue to earn years of service toward your URS retirement.
- **If you were hired on or after July 1, 2011**, you may continue to earn years of service credit toward URS retirement if your employer has signed a benefit protection contract. Check with your employer.

Are there limits to my benefit?
Medical or psychological conditions that existed prior to eligibility may not be a basis for LTD benefits until you have had one year of continuous LTD eligibility.

How long can I receive LTD benefits?

If you are unable to perform your regular job and you remain disabled, you may remain on disability up to 24 months.

At the end of 24 months, you can apply for ongoing benefits if you can't perform any gainful employment, based on objective medical documentation.

As long as you meet the disability requirements you can remain on LTD until you reach age 65 or have enough years of service toward retirement to retire, whichever comes first.

If you become disabled at or after age 60, LTD is payable as follows (unless you accrue enough years of service toward retirement to retire first):

Age 60 or 61	»	five years
Age 62 or 63	»	four years
Age 64 or 65	»	three years
Age 66, 67 or 68	»	two years
Age 69 or older	»	one year

PEHP
Long-Term Disability

560 East 200 South
Salt Lake City, UT 84102

801-366-7583 | 800-365-7347

Email us: pehp.ltd@pehp.org

More info: visit www.pehp.org

Does other income affect my LTD benefits?

LTD benefits are reduced when you receive income from sources such as Social Security, workers' compensation, third-party payments, sick/vacation pay and wages from rehabilitative employment.

Note: This brochure offers a brief overview only. For more detailed information about your LTD benefits, go to www.pehp.org.

The LTD Program is established by Title 49 of Utah Code at 49-21-101. The information here provides a general description of benefits provided and is for informational purposes only. No error, misrepresentation or ambiguity in this information creates any rights or benefits not expressly granted by Utah Code Title 49.

3-16-23

PEHP Life & Accident

NOTE: Depending on your employer's choice of Life & Accident plans, this brochure's benefits may not apply. Please refer to your employer or contact PEHP Group Term Life and AD&D for details.

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

COVERAGE	AMOUNT
Up to Age 70	50,000
Age 71 to 75	25,000
Age 76 and over	12,500

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.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.20	2.40	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 30 to 34	1.30	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
Age 35 to 39	1.80	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00
Age 40 to 44	2.20	4.40	8.80	13.20	17.60	22.00	26.40	30.80	35.20	39.60	44.00
Age 45 to 49	4.20	8.40	16.80	25.20	33.60	42.00	50.40	58.80	67.20	75.60	84.00
Age 50 to 54	5.10	10.20	20.40	30.60	40.80	51.00	61.20	71.40	81.60	91.80	102.00
Age 55 to 59	8.10	16.20	32.40	48.60	64.80	81.00	97.20	113.40	129.60	145.80	162.00
Age 60 to 69	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes											
Coverage Amounts	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	12,500	25,000	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	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life & Accident

SPOUSE BASIC COVERAGE: Your employer funds $10,000 of spouse basic coverage at no charge to you.

SPOUSE ADDITIONAL TERM COVERAGE

You can buy up to $500,000 in spouse coverage. If you apply within 60 days of your hire date or marriage date, up to $50,000 is guaranteed issue. After 60 days, and for all amounts above $50,000, you must complete a health statement.

Monthly Rates	25,000	50,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 30	1.20	2.40	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 30 to 34	1.30	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
Age 35 to 39	1.80	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00
Age 40 to 44	2.20	4.40	8.80	13.20	17.60	22.00	26.40	30.80	35.20	39.60	44.00
Age 45 to 49	4.20	8.40	16.80	25.20	33.60	42.00	50.40	58.80	67.20	75.60	84.00
Age 50 to 54	5.10	10.20	20.40	30.60	40.80	51.00	61.20	71.40	81.60	91.80	102.00
Age 55 to 59	8.10	16.20	32.40	48.60	64.80	81.00	97.20	113.40	129.60	145.80	162.00
Age 60 to 69	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes											
Coverage Amounts	13.70	27.40	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	12,500	25,000	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	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

Your employer funds $10,000 of dependent children coverage at no charge to you. If you apply within 60 days of your hire date or the date of the child's birth, all amounts are guaranteed issue. After 60 days, a health statement will be required for each child. All eligible children will be covered at the same level for one premium. Children can be covered until married or age 26, whichever comes first.

CHILD BASIC COVERAGE: Your employer funds $10,000 at no cost to you.

Coverage Amount	10,000	15,000
Monthly cost	0	0.52

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

Your employer funds $50,000 of AD&D coverage at no charge to you. Select additional coverage from $25,000 to $200,000 for a maximum coverage of $250,000.

Employee's Coverage Amount	Individual Plan Monthly Cost	Family Plan Monthly Cost
50,000	0	0.50

FAMILY PLAN

- Upgrade your individual AD&D plan to a family plan. Convert your employee-funded $50,000 individual plan to a $50,000 family plan at a cost of 0.50 per month.
- Select a coverage amount ranging from $25,000 to $200,000, 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.

PEHP Life & Accident

Accidental Death and Dismemberment (AD&D)

Additional AD&D Coverage and Cost

INDIVIDUAL PLAN		FAMILY PLAN
Coverage Amount	Monthly Cost	Monthly Cost
25,000	0.50	0.75
50,000	1.00	1.50
75,000	1.50	2.25
100,000	2.00	3.00
125,000	2.50	3.75
150,000	3.00	4.50
175,000	3.50	5.25
200,000	4.00	6.00

AD&D Payment Schedule

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.

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.

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

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	MONTHLY COST
250 and under	25	0.28
251 to 599	50	0.52
600 to 700	75	0.76
701 to 875	100	1.00
876 to 1,050	125	1.28
1,051 to 1,200	150	1.52
1,201 to 1,450	175	1.76
1,451 to 1,600	200	2.04
1,601 to 1,800	225	2.28
1,801 to 2,164	250	2.52
2,165 to 2,499	300	3.00
2,500 to 2,899	350	3.52
2,900 to 3,599	400	4.04
3,600 and over	500	5.04

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	MONTHLY COST
$ 2,500	$ 1.18