Welcome to Open Enrollment 2025-26

This packet provides important information about the State of Utah Risk Pool's benefits for the upcoming year. It includes your 2025-26 rates and Benefit Selection Form, which allows PEHP to track changes to your benefits each year.

Follow these steps to get ready for Open Enrollment (OE):

- Review the Open Enrollment Timeline to the right -->
- Register for the OE Kick-Off Meeting on April 1 (page 2)
- Review benefit changes and coverage options (pages 3-7)
- Review the new plan year rates (page 8)
- Fill out the 2025 Benefit Selection Form. Please return the completed form before your OE begins, but no later than Wednesday, April 2.

Open Enrollment Timeline

April 1, 2025
State Risk Pool OE Kick-Off Meeting

April 2, 2025: Benefits Selection Form deadline*

April 7 - May 7, 2025:** Open Enrollment period for State Risk Pool

July 1, 2025: New plan year begins

In This Document

Questions?

Contact your PEHP Client Services Rep:

Taylor Hooton
801-231-1008
Taylor.Hooton@pehp.org

* We need your form returned before Open Enrollment starts for your agency to update any benefits.

** You do not need to follow the State OE period. If you would like to specify different dates, please note the dates in the "Open Enrollment" section of the Benefit Selection Form. We cannot guarantee ID cards will be mailed in time for the new plan year.

New PEHP System July 1

How This Affects Employers

Enrollment

To ensure a smooth transition, employee enrollment must be completed by Friday, May 16. This deadline applies whether you submit data manually or via a third-party/ EDI feed. Meeting this deadline allows us to process enrollments, transfer data to our new system, and issue new ID cards before July 1.

Billing Changes

- Currently, bills are sent retrospectively (after coverage is provided).
- Starting July 1, you will receive bills prospectively around the 15th of each month.
- Your first prospective bill for premiums will arrive in June for the July coverage period.

New Employer Portal & Employee Certifications

- A new Employer Portal will allow you to manage coverage, pull invoices, enroll/waive employees, and process terminations.
- There will be a new certification process for new employees
- More details on portal access and features will be provided soon.

Life & Accident Products

- These products will not migrate to the new system yet.
- You will receive two separate bills each month - one for premiums (New system) and one for Life/ AD&D (Classic system).
- Certification for Life/AD&D enrollment is still required in the Classic PEHP Portal if your employees use PEHP.org for to enroll.

Set up Automated Clearing House (ACH)

We are transitioning to electronic fund transfers to enhance the efficiency and security of our billing and payment processes. To assist us in this transition, please opt in to ACH payments for your group bills.

Enrolling is simple – just check the appropriate box on page 2 of the Benefit Selection Form. Our Finance team will then follow up with a secure email to complete the setup before July.

For Medical and Dental plans, payments will be deducted on the 5th of each month. Other lines, such as Life and LTD, will continue on the current billing cycle, and our Finance team will work with you to confirm your preferred payment timing.

Thank you for your cooperation in streamlining our payment process!

How This Affects Employees

New Member Number & ID

- Members will receive a new ID number and card effective July 1.
- Employees must update their ID number with providers and pharmacies to prevent claim disruptions.
- Old ID numbers will no longer work after July 1
- Members will have a new PEHP Online Account to access claims

We will schedule trainings to go through the Employer Portal and other important system updates in May or June.

Benefit Changes & Reminders

State Risk Pool Renewal 2025-26

5.2% Medical increase
6.9% PEHP Dental renewal
5.9% EMI Dental renewal

Notes on State Rate Sheets

Premium Differential by Network: Last year, groups had the option to choose between the original or modified rates due to late changes to the renewal rates. This year, if you didn't choose the modified rates, you'll see different billed premiums for Advantage and Summit networks. Contact your Marketing Rep for questions.

Monthly Rates: Due to the system change, you'll be billed the monthly rates shown on page 8. Invoices will be for the upcoming month and automatically adjust retroactive changes.

HCR002: Pharmaceutical Rebates: This bill allows members to get rebates at the pharmacy when filling certain prescriptions. This increases costs for State plans since the Risk Pool no longer receives the rebates. The State opted to apply the cost to the employee portion of premiums. Since the cost for this benefit is not factored into the renewal rates, it would not be included in any State funding your agency may receive. If you want to stay cost neutral like the State, you may consider adjusting your normal cost sharing, or applying the same per member per month (PMPM) cost to employee premiums:

- Single: $2.78
- Double: $5.70
- Family: $7.62

STAR HSA Changes

STAR Plan will have higher deductibles to meet Federal guidelines for qualified high deductible plans:

- **Single: $1,650** (was $1,600)
- **Double/Family: $3,300** (was $3,200)

Consumer Plus HSA Contribution Changes

* If your agency offers Consumer Plus, and follows the State's HSA contributions. *

The annual contributions will change due to costs from HCR002. Advantage increases - along with employee premium - and Summit decreases. Contributions will now be the same regardless of medical network.

Consumer Plus Plan			
	2024-25 ADVANTAGE	2024-25 SUMMIT	2025-26 BOTH NETWORKS
Single	$1,824.68	$1,968.20	**$1,934.92**
Double	$3,649.62	$3,961.36	**$3,893.24**
Family	$3,649.62	$4,078.10	**$3,986.84**

Benefit Changes & Reminders

Updates to Infertility Benefits

SB242 - Assisted Reproductive Technology (ART), including IVF and other similar services, will no longer have a $4,000 limit. These services will now be covered under regular benefits, subject to deductible and plan coinsurance. The benefits are still limited to single embryo implants, in addition to existing eligibility and prior authorization guidelines.

2025 Health Account Limit Increases

» **Health Savings Account (HSA) Contribution Limits -** Apply to the 2025 calendar year.

- $**4,300 single** (was $4,150)
- $**8,550 family** (was $8,300)

» **Flex Spending Account (FSA) Contribution Limits** - Apply to the 2025-26 plan year.

- **Annual Contribution Limit: $3,300** (was $3,200)
- **Carryover Limit*: $660** (was $640)

* For plan year ending June 30, 2026. Carryover only applies to agencies offering the FLEX$ Rollover option.

Basic Life Insurance Increase & LTD Program Enhancements

SB0022 - Since PEHP reduced rates for Long Term Disability (LTD) premiums - last September - the State of Utah is applying the LTD premium savings to increase the employer-paid Basic Life policy amount from $25,000 to $50,000 per benefit-eligible employee.

If offering Life benefits through PEHP, you may choose to increase the Basic amount as well. A $50k Basic Life policy would be **$5.45/employee per month**. This cost includes the Line of Duty and Accidental Death Riders. Please indicate any changes on your Benefit Selection Form.

As a reminder, the following LTD changes went into effect on September 1, 2024:

› Reduced rate: Base premium rate decreased from .5 % to 0.475% of total employee salary for a two-thirds monthly salary replacement benefit. Note: the base rate is different if enrolled in mental health pilot.

› Enhanced Survivor Benefit: Survivors will receive 3 times the LTD monthly benefit.

› EAP Services: Access to employee life assistance counseling from Blomquist Hale.

› Public Safety Overtime: Inclusion of public safety overtime (up to 10 hours OT per week) in LTD wage replacement calculations.

› Updated Occupation Definition: Revised to a 60% pre-disability earnings requirement.

If you do not currently offer our LTD product and would like to learn more about the benefits and enhancements, please reach out to your PEHP Marketing Rep.

Optional Benefits/Medical Riders

Opt-Out Benefit

Agencies may follow the State's Opt Out Benefit model, which allows employees with other medical and/or dental coverage to waive employer coverage for a cash incentive.

If you have your own Opt Out program but would not like PEHP to handle enrollment, please note that on your Benefit Selection Form under the Opt Out sections.

Employee Requirements:

» Employees must have qualifying medical and/or dental coverage to opt out. Medicaid, Medicare, and Individual Marketplace Coverage are not qualified coverages. Incentive payments are taxable.

PEHP's Role:

» Enrollment and reporting (if using PEHP's enrollment portal) by adding Opt-Out as a plan option in online enrollment for either Medical Only, Dental Only, or both Medical and Dental.

Employer's Role:

» Employers are responsible for all incentive payments. You may determine the amount and distribution rules for your employees or follow the State's default program:

Annual Medical Incentive (paid biweekly):

	Annual	Biweekly
Single	$2,000	$76.93
Double/family	$4,000	$153.85

Annual Dental Incentive (paid biweekly):

	Annual	Biweekly
Single	$100	$3.85
Double/family	$200	$7.70
Family	$400	$15.35

Consumer Plus Medical Plan

Groups in the State Pool can offer the Consumer Plus medical plan - a qualified high-deductible health plan (HDHP) with minimum essential benefits. It has its own Master Policy and Covered Drug List, with fewer covered services and prescription drugs. It also has a much higher deductible and out-of-pocket maximum than STAR HSA, and a 30% coinsurance (vs. 20% on Traditional and STAR HSA).

To offset higher plan limits and limited benefits, employees pay less (or no) premium, and receive a higher employer HSA contribution than the STAR HSA plan.

Domestic Partner Coverage

Domestic Partner benefits apply to those in a committed relationship. There is no additional cost added to the premium for the benefit. The cost to you is any added premium cost related to tier change (i.e.,, employee going from a single party to a two party plan).

If you offer this benefit, you are required to check eligibility, use the PEHP affidavit, maintain records, and impute income as necessary. You can elect this benefit on your Benefit Selection Form.

Other Reminders

Other Benefits

» **Pharmacy**
PEHP's Covered Drug List is modified periodically with changes based on recommendations from PEHP's Pharmacy and Therapeutics Committee. The State STAR HSA plan includes the Expanded Preventive Medication List, see page 10. The list is included in the Covered Drug List.

» **FIA Care**
Whether you need virtual visits, at-home care, support with chronic conditions or prescription renewals - Fia Care is here to make healthcare easy. Primary care or fee-for-service model available. Learn More

» **Healthy Utah At-Home Testing**
We know life can get busy, but taking care of your health is essential. That's why we've expanded our Healthy Utah program to include a free at-home biometric screening through our trusted partner, Reperio Health, to help members check in on their health from the comfort of home. This quick and easy screening checks vital health measures like blood pressure, cholesterol, and glucose to help catch potential issues early. If you would like to offer this benefit to your employees, let us know.

» **Free Continuous Glucose Monitor Now Available**
We've expanded our diabetes benefits to include coverage of the **FreeStyle Libre Continuous Glucose Monitor** as preventive, meaning your employees have access to this device at no cost. The new FreeStyle Libre 3 plus now offers upgraded features that meet or exceed those of Dexcom. The Dexcom CGM will still be covered at the same benefit, Tier 3. However, members using Dexcom may want to switch to take advantage of the cost savings. See other diabetes benefits

» **PEHPPlus Discount Program**
PEHPplus provides savings on various healthy lifestyle products and services not covered by insurance. We frequently add new discounts, categories, and vendors to this program, so check back often. See Discounts

2025-26 Active Rates - Monthly

Important Note: These rates show the State of Utah Risk Pool's full plan offering and employer/employee cost share amounts. Your agency may not offer all plans, use the same cost share or the same HSA contribution amounts.

State Risk Pool employers are responsible for the total premium for each plan offered, and may determine employee share at their discretion.

STATE RISK POOL Monthly Rates

ADVANTAGE MEDICAL NETWORK

	Employer	**Employee**	Total
STAR HSA			
SINGLE	$651.78	**$22.28**	$674.06
DOUBLE	$1,369.52	**$46.78**	$1,416.30
FAMILY	$1,869.70	**$63.84**	$1,933.54
TRADITIONAL			
SINGLE	$759.04	**$79.54**	$838.58
DOUBLE	$1,562.98	**$163.92**	$1,726.90
FAMILY	$2,083.40	**$218.74**	$2,302.14
CONSUMER PLUS			
SINGLE	$578.06	**$17.28**	$595.34
DOUBLE	$1,201.74	**$37.62**	$1,239.36
FAMILY	$1,709.98	**$51.66**	$1,761.64

SUMMIT MEDICAL NETWORK

	Employer	**Employee**	Total
STAR HSA			
SINGLE	$651.78	**$2.78**	$654.56
DOUBLE	$1,369.52	**$5.70**	$1,375.22
FAMILY	$1,869.70	**$7.62**	$1,877.32
TRADITIONAL			
SINGLE	$759.04	**$53.86**	$812.90
DOUBLE	$1,562.98	**$111.16**	$1,674.14
FAMILY	$2,083.40	**$148.42**	$2,231.82
CONSUMER PLUS			
SINGLE	$578.06	**$-**	$578.06
DOUBLE	$1,201.74	**$-**	$1,201.74
FAMILY	$1,709.98	**$-**	$1,709.98

MONTHLY DENTAL CONTRIBUTIONS

	Employer	**Employee**	Total
TRADITIONAL DENTAL			
SINGLE	$28.38	**$5.70**	$34.08
DOUBLE	$52.66	**$10.54**	$63.20
FAMILY	$95.78	**$19.20**	$114.98
PREFERRED CHOICE			
SINGLE	$28.38	**$3.16**	$31.54
DOUBLE	$52.66	**$5.86**	$58.52
FAMILY	$95.78	**$10.66**	$106.44
BASIC HSA DENTAL			
SINGLE	$21.44	**$-**	$21.44
DOUBLE	$39.82	**$-**	$39.82
FAMILY	$72.38	**$-**	$72.38
DISCOUNT HSA DENTAL			
SINGLE	$1.40	**$-**	$1.40
DOUBLE	$2.80	**$-**	$2.80
FAMILY	$6.22	**$-**	$6.22
EMI DENTAL			
SINGLE	$28.38	**$15.96**	$44.34
DOUBLE	$52.66	**$25.58**	$78.24
FAMILY	$95.78	**$42.96**	$138.74

MONTHLY VISION CONTRIBUTIONS

	Employer	**Employee**	Total
EYEMED FULL			
SINGLE	$-	**$10.16**	$10.16
DOUBLE	$-	**$14.72**	$14.72
FAMILY	$-	**$19.24**	$19.24
EYEMED EYEWEAR ONLY			
SINGLE	$-	**$9.18**	$9.18
DOUBLE	$-	**$12.82**	$12.82
FAMILY	$-	**$16.48**	$16.48

Annual State Medical HSA Contributions*

STAR HSA Plan		Consumer Plus Plan	
Single	$1,034.28	**Single**	$1,934.92
Double	$1,826.76	**Double**	$3,893.24
Family	$1,918.54	**Family**	$3,986.84

Annual State Dental HSA Contributions*

Basic HSA Dental		Discount HSA Dental	
Single	$74.88	**Single**	$234.26
Double	$139.88	**Double**	$429.00
Family	$254.54	**Family**	$782.86

*The State distributes to their employees twice per year: half in July, half in January. State Risk Pool groups may choose any HSA employer contribution amount and distribution frequency.

PEHP Health & Benefits

STAR HSA

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,650 Double/family plans: $3,300 *One person or a combination can meet the $3,300 double/family deductible*	
Plan year Out-of-Pocket Maximum	Single plans: $3,000 Double plans: $4,000 per person, $6,000 per double Family plans: $4,000 per person, $9,000 per family *One person can only meet $4,000, or a combination can meet the 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 inpatient visits and Autism services*	20% after deductible	40% after deductible
Specialist Visits *Includes inpatient visits and Autism services*	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	20% after deductible	20% after deductible
Diagnostic Tests, Labs, X-rays	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The STAR Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost. $25 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $50 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost. $50 minimum, no maximum co-pay **Tier 3:** 50% of discounted cost. $100 minimum, no maximum co-pay	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. Member pays any balance

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

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption	20% after deductible, up to $4000 per adoption	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 10 visits per plan year*	20% after deductible	Not covered
Durable Medical Equipment *Some DME requires Preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Home Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services/Assisted Reproductive Technology (ART) *Diagnostic services only. ART requires preauthorization. Excludes multiple embryo ART implants. 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 (Non-HSA)

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

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

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

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

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 30%. No maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 30% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 50% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 30%. $225 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	$45 co-pay per visit	40% after deductible
Emergency Room *Emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	20% of In-Network Rate, minimum $150 co-pay per visit	20% of In-Network Rate, minimum $150 co-pay per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays	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	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption	20% after deductible, up to $4000 per adoption	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 10 visits per plan year*	Applicable office co-pay per visit	Not covered
Durable Medical Equipment *Some DME requires Preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	20% after deductible	40% after deductible
Home Hospice	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services/Assisted Reproductive Technology (ART) *Diagnostic Services Only ART requires Preauthorization. Excludes multiple embryo ART implants. See Master Policy for details*	20% after deductible per single-embryo ART implant	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	20% after deductible	40% after deductible

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

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

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

PEHP Health & Benefits

Consumer Plus

(HSA-Qualified)
Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

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

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

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

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

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

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

2025-26 Pharmacy Benefits

Please refer employees to PEHP's Covered Drug List (or Consumer Plus Covered Drug List, if offered), for questions and details on prescriptions.

The chart below includes your Pharmacy benefits for 30-day and 90-day prescriptions. View the Expanded Preventive Medications list for members on the STAR HSA plan on the following page.

Refills at retail and/or mail-order are not payable until 75% of the total supply within the last 180 days is used. Refer to the Master Policy or PEHP Formulary for a list of medicines provided at no cost under the Affordable Care Act. Pharmacy charges will apply to the deductible and out-of-pocket maximum for members enrolled in The STAR Plan.

OPTION D

30-Day Pharmacy (Retail only)	
Tier 1	$10 co-pay
Tier 2	25% of discounted cost, $25 min./no max.
Tier 3	50% of discounted cost, $50 min./no max.
90-Day Pharmacy (Maintenance only)	
Tier 1	$20 co-pay
Tier 2	25% of discounted cost, $50 min./no max.
Tier 3	50% of discounted cost, $100 min./no max.

Expanded Preventive **Medications**

STAR HSA Plan

As a reminder, STAR HSA plans in the State Risk Pool include Expanded Preventive Medication benefits. This means PEHP will pay a portion of the drug cost even before individuals meet their deductible. Make sure employees visit an in-network pharmacy to receive this benefit.

Diabetes

GLUCOSE RESCUE PRODUCTS
GlucaGen HypoKit
Glucagon
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

1-9-24

Summit

CommonSpirit (Holy Cross), **MountainStar**, and **University of Utah Health Care** providers and facilities.

Participating Hospitals

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
- Holy Cross Hospital - Davis
- 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
- Holy Cross Hospital - Jordan Valley
- Holy Cross Hospital - Jordan Valley West
- Holy Cross Hospital - Salt Lake
- Huntsman Cancer Hospital
- Lone Peak Hospital
- Primary Children's Medical Center
- Riverton Children's Unit
- St. Marks Hospital
- 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 Regional Medical Center

Utah County
- Holy Cross Hospital - Mountain Point
- Mountain View Hospital
- Primary Children's Hospital – Lehi
- Timpanogos Regional Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- St. George Regional Medical Center

Weber County
- Ogden Regional Medical Center

PEHP Health & Benefits

Advantage

Intermountain Health providers and facilities.

Participating Hospitals

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
- Holy Cross Hospital - Davis
- 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
- 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 Regional Medical Center

Utah County
- American Fork Hospital
- Orem Community Hospital
- Primary Children's Hospital – Lehi
- Spanish Fork Hospital
- Utah Valley Hospital

Wasatch County
- Heber Valley Medical Center

Washington County
- St. George Regional Medical Center

Weber County
- McKay-Dee Hospital

Non-Contracted Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit. Find participating providers and see a list of Non-Contracted Providers at www.pehp.org.

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

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

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

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

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

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

*** AD** = After Deductible

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

Basic HSA Dental Care

Must be on STAR HSA or Consumer Plus Plan

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

*** AD** = After Deductible

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

Discount HSA Dental Care

Must be on STAR HSA or Consumer Plus Plan

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

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

Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

DENTAL COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES
OUTLINE OF COVERAGE

Read Your Policy Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Group:	**State of Utah (Plan #1580)**
Plan:	**Choice Indemnity**
Underwritten & Administered by:	**Educators Health Plans Life, Accident & Health, a Utah Company**
Effective Date:	**7/1/2025**
Benefit Year:	**Contract**
Plan Type:	**Contributory / Fully Insured**

	In-Network (Advantage *Plus* Network)	In-Network (Premier Network)	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	**100%**	**100%**	**100% up to R&C**
Type 2 - Basic Fillings, Oral Surgery	**80%**	**80%**	**80% up to R&C**
Type 3 - Major Crowns, Bridges, Prosthodontics	**50%**	**50%**	**50% up to R&C**
Type 4 - Orthodontics Dependent children ages 7 through 18	**50%**	**50%**	**50%**
Adults	Discount Only	Discount Only	No Coverage
Endodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Sealants	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Space Maintainers	Type 1 - Preventive	Type 1 - Preventive	Type 1 - Preventive
Waiting periods			
Type 2 - Basic	None		
Type 3 - Major	None		
Type 4 - Orthodontics	None		
Deductible	In and Out of Network Deductibles are Combined		
Per Person	$0.00	$0.00	$0.00
Family Max	$0.00	$0.00	$0.00
Deductible Applies To	N / A	N / A	N / A
Annual Maximum Per Person	$2,000.00	$1,500.00	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum	$1,500.00		
Network / Reimbursement Schedule	Advantage Plus Dentemax	Premier	R & C (80th)

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

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

* Anesthesia is not subject to waiting periods.

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)

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)