PEHP Health & Benefits

USU-Eastern Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024
OPEN ENROLLMENT: MAY 1–MAY 31, 2023

Your To-Do Checklist

1 Medical Options

- [ ] STAR HSA Plan
- [ ] Traditional Plan

2 Network Options

- [ ] Summit
- [ ] Advantage

If you're happy with your current benefits, you don't need to do anything, except re-enroll in FLEX$ if you have a FLEX$ account.

Navigating This Guide

Click the icons below for detailed information about each topic

Benefit Changes & Reminders
Medical Grids
Health Accounts
Things to Consider
Medical Networks
Wellness & Other Benefits
Medical Plans
Vision Coverage
Cost Tools
Plans at a Glance
Plan Rates

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

Benefit Changes & Reminders

Expanded Maternity Benefits

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

Mental Health Emergencies

If you have an emergency, you can get immediate help by calling the national crisis line at 988. You and your family can get counseling services at no cost and for any reason through Blomquist Hale. Services are confidential, and they also offer a 24/7 crisis hotline. Call them at 1-800-926-9619. Learn more

Choose Your Own Path to Wellness

Our new wellness webpage is packed with programs and activities to jump start your journey to a healthier you - on your own time! Whether you're trying to be more active, improve your eating habits, boost your mental well-being, or get parenting support - you'll find something to help you achieve your health and wellness goals. Plus, you can earn cash rebates and prizes when you participate in our programs. See options

» *PEHP specialist Taylor Hooton*

Things to Consider
before choosing medical plan

1 How often do you use your medical plan?

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

Did you know?
You can download your claims history from your PEHP account to see how much you spend on healthcare annually.

2 How much will covered healthcare cost you?

Annual premium - see page 4 for plan amounts

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

Deductible & Out-of-Pocket Maximum (OOPM)

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

3 What if I have other insurance?

Dual Coverage/Coordination of Benefits: You are allowed to have two different plans. This will give you more coverage for your health insurance. Double check what you're paying for each plan to see whether paying for two plans is cost effective or not.

Medical Plans

A STAR HSA Plan

Single Double Family

Your Annual Cost

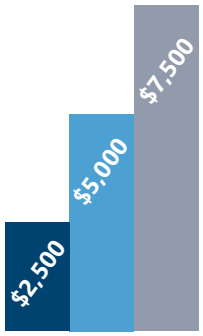
Single
$143.04

Double
$295.80

Family
$405.60

Medical Deductible
Medical & Pharmacy

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



Plan Benefits

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

Review coverage and benefit details on page 6.

B Traditional Plan

Your Annual Cost

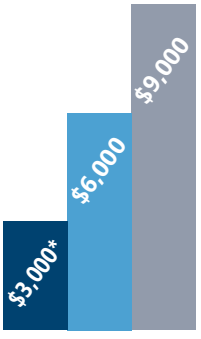
Single
$1,170.48

Double
$2,408.04

Family
$3,214.08

Medical Deductible
Medical & Pharmacy

Out-of-Pocket Maximum
Medical & Pharmacy



Plan Benefits

Review coverage and benefit details on page 9.

*per individual

See Medical Plan Costs

Plans at a Glance

A STAR HSA Plan

- You pay a lower premium from your paycheck.
- HSA funds carry over from year-to-year and grow tax-free. You never forfeit what you don't spend.
- It covers more preventive services paid at 100% compared to other plans, including chronic medications like diabetes. See a list of medications on page 19 of the Covered Drug List.

B Traditional Plan

- It has a lower deductible and gives you predictable costs through fixed co-pays.
- Each family member has their own deductible and out-of-pocket maximum.
- Deductible does not apply to out-of-pocket maximum.

PEHP Health & Benefits

STAR HSA

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

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

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

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

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

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

PEHP Health & Benefits

Traditional (Non-HSA)

Summit & Advantage

MEDICAL BENEFITS GRID: WHAT YOU PAY

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

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

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

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

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

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

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

Medical Networks

DID YOU KNOW?

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

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

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

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Intermountain Layton Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Alta View Hospital
Intermountain Medical Center
The Orthopedic Specialty Hospital (TOSH)
LDS Hospital

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

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
McKay-Dee Hospital

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

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

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital
Brigham City Community Hospital

Cache County
Cache Valley Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Lakeview Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Huntsman Cancer Hospital
Jordan Valley Hospital
Jordan Valley Hospital - West
Lone Peak Hospital

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

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

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

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
Ogden Regional Medical Center

Non-Covered Providers

PEHP doesn't pay for any services from certain providers, even if you have an out-of-network benefit.
See a list of Non-Covered Providers.

Need Vision Coverage?

Several Ways to Address Your Vision Needs » You get vision exams through your medical plan and shop for frames and lenses using pre-tax dollars. Or buy a vision plan to cover the bulk of vision costs. Do the math to see what's best for you. Here's a summary.

With the STAR HSA Plan

Did you know that members on the STAR HSA Plan get one annual vision exam covered at 100% before deductible? If you're on The STAR HSA plan, take advantage of this great benefit to get a prescription from your in-network optometrist for lenses. Then shop around and use HSA dollars to pay for lenses and frames tax-free.

With the Traditional Plan

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

Funding Through Opticare

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

Funding Through EyeMed

You get your choice of two plans. One covers eyewear only while the other includes an eye exam. You may get a discount on frames from the sticker price.

See Vision Plan Costs

OpticareVision services

OPTICARE PLAN – PEHP – Eye Exam & Hardware Benefits

0-10-150/140C

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

OpticareVision services

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

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

EyeMed

PEHP Full

40% OFF
additional complete pair of prescription eyeglasses

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

Find an eye doctor
(Insight Network)

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

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

SUMMARY OF BENEFITS

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

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

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

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

EyeMed

PEHP Eyewear Only

40% OFF
additional complete pair of prescription eyeglasses

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

Find an eye doctor

(Insight Network)

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

Heads up

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

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Progressive – Standard	$75 copay	Up to $40
Progressive – Premium Tier 1 - 3	$95 - 120 copay	Up to $40
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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)

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.

Utah State University - Eastern
Monthly Insurance Premiums

Full-Time Benefitted Employee (**2023-2024 *New Plan Year***)

Below are the monthly Insurance premiums for Benefitted employees working at least 30 hours per week.

If you are a Benefitted employee and work less than 30 hours per week, please see Part-Time Premium information.

Utah State University-Eastern pays an average premium of $1,332 per participating employee per month in our Health Plan.

Utah State University-Eastern pays an average premium of $53 per participating employee per month in our Dental Plan.

Star Health Insurance Plan (HDHP)

Star Summit or Advantage Network

Coverage Level	
One Person	$11.92
Two People	$24.65
Three or More People	$33.80

Traditional Health Insurance Plan

Traditional Summit or Advantage Network

Coverage Level	
One Person	$97.54
Two People	$200.67
Three or More People	$267.84

Average USU-Eastern Health Premium Contribution	**$1,332.02**
Average USU-Eastern Dental Premium Contribution	**$52.90**

Dental Insurance

Coverage Level	
One Person	$6.92
Two People	$13.12
Three or More People	$22.60

Utah State University - Eastern
Monthly Insurance Premiums

Part-Time Benefitted Employee (**2023-2024 *New Plan Year***)

Below are the monthly Insurance premiums for Benefitted employees working less than 30 hours per week (50%-74% FTE).

If you are a Benefitted employee and work more than 30 hours per week, please see Full-Time Premium information.

Utah State University-Eastern pays an average premium of $1,332 per participating employee per month in our Health Plan.

Utah State University-Eastern pays an average premium of $53 per participating employee per month in our Dental Plan.

Star Health Insurance Plan (HDHP)

Star Summit or Advantage Network

Coverage Level	
One Person	$216.31
Two People	$447.47
Three or More People	$613.50

Traditional Health Insurance Plan

Traditional Summit or Advantage Network

Coverage Level	
One Person	$320.08
Two People	$659.66
Three or More People	$880.60

Average USU-Eastern Health Premium Contribution	**$1,332.02**
Average USU-Eastern Dental Premium Contribution	**$52.90**

Dental Insurance

Coverage Level	
One Person	$16.39
Two People	$31.55
Three or More People	$56.71

PEHP Wellness Programs

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

» **Biometric Screenings** - Subscribers and their spouses are eligible to attend one Healthy Utah biometric screening each plan year free of charge.

» **Earn Cash Rebates*** – Get cash rewards for participating in wellness programs and activities.

» **Diabetes Management** – Receive education and support from a registered dietitian to manage or prevent diabetes.

» **Pregnancy Resources** – Enroll in PEHP WeeCare to get pregnancy and postpartum support to help you have the healthiest and safest pregnancy possible. Members can enroll online at any time during pregnancy.

» **Healthy Eating** – Practice expert strategies to plan healthy meals, streamline grocery shopping, and try new ingredients to avoid menu monotony.

» **Weight Management** – Meet your health and weight management goals with personalized help from a health coach and registered dietitian.

» **Physical Activity** – Stay active and physically fit with weekly motivational tips and resources from a certified personal trainer.

» **Mental & Emotional Well-Being** – Stay on top of your mental and emotional health with several tips, exercises, and resources.

» **Financial Wellness** – Get on track with personal finances to create financial peace of mind.

» **Family & Social Well-Being** – Check out a library of parenting materials or virtually attend monthly parenting classes.

» **Webinars** – Learn about current health and wellness topics.

FOR MORE INFORMATION

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

Value Added Benefits

Diabetes Savings Program

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

FOR MORE INFORMATION

» **Web:** www.pehp.org/diabetes

Legal Guardianship

This benefit allows children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. To continue coverage, the guardian child must have been enrolled in coverage prior to being 18 years of age and met the federal qualifications for coverage as a guardian child. Call PEHP to learn more, 801-366-7555 or 800-765-7347.

PEHPplus

PEHPplus provides savings of up to 50 percent on a wide assortment of healthy lifestyle products and services, such as eyewear, gyms, Lasik, and hearing. We're frequently adding new discounts, so check it out at www.pehp.org/pehpplus.

PEHP Value Providers

PEHP Value Providers include outstanding healthcare providers available to PEHP members with the lowest out-of-pocket costs. The next time you need care, don't forget these options for value and convenience.

FOR MORE INFORMATION

» **Web:** www.pehp.org/valueproviders

Preventive Care

Stay healthy by getting preventive screenings every year. Preventive benefits are covered at no cost to you when you see an in-network provider – even before you meet your deductible. See your preventive care checklist at www.pehp.org/preventiveservices

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

PEHP Health & Benefits

USU-Eastern

Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024

OPEN ENROLLMENT: MAY 1–MAY 31, 2023

Life Assistance Counseling

Blomquist Hale SOLUTIONS

WHEN LIFE GETS CHALLENGING WE CAN HELP

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

Count On:

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

WE CAN HELP WITH

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

PEHP Health & Benefits

USU-Eastern

Benefits Guide

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PEHP Cost Tools

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

You may even find cash back.

Learn more: www.pehp.org/save

PEHP Health & Benefits

Health Accounts

Health Savings Account (HSA)

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

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

You must be enrolled in a high deductible health plan such as STAR HSA.

HSA contribution limits for calendar year 2023:

Single: $3,850

Double/Family: $7,750

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

Flexible Spending Account (FLEX$)

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

- Great option to save for expenses if you're not eligible for an HSA.
- If you sign up for a FLEX$ account, PEHP will frontload your elected funds at the beginning of the plan year and issue you a Mastercard to use as payment for eligible expenses. Eligible expenses are set by the IRS.
- FLEX$ accounts are use-or-lose.
- You must enroll in FLEX$ each year during open enrollment to participate.

You can contribute up to $3,050 in calendar year 2023.

Learn More

Did you know?

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

See HSA Contributions

PEHP Health & Benefits

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EFFECTIVE: JULY 1, 2023–JUNE 30, 2024

OPEN ENROLLMENT: MAY 1–MAY 31, 2023

USU-Eastern Benefits Guide

USU-EASTERN

Benefits Guide

Effective July 2023

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

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

This Benefits Summary is for informational purposes only and is intended to give a general overview of the benefits available under those sections of PEHP designated on the front cover. This Benefits Summary is not a legal document and does not create or address all of the benefits and/or rights and obligations of PEHP.

The PEHP Master Policy, which creates the rights and obligations of PEHP and its members, is available upon request from PEHP and online at www.pehp.org. All questions concerning rights and obligations regarding your PEHP plan should be directed to PEHP.

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

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

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