PEHP Health & Benefits

Mountainland Technical College Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024
OPEN ENROLLMENT: APRIL 24–MAY 17, 2023

Your To-Do Checklist

1 Medical Options

- ☐ STAR HSA Plan
- ☐ Traditional Plan
- ☐ Consumer Plus Plan

2 Network Options

- ☐ Summit
- ☐ Advantage

3 Dental Options

- ☐ Preferred
- ☐ Traditional
- ☐ EMI Choice Indemnity

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

Navigating This Guide

Click the icons below for detailed information about each topic

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

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

PEHP Health & Benefits | PROUDLY SERVING UTAH PUBLIC EMPLOYEES

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

Other Insurance Coverage

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

New Dental Option

You have several dental options, including a new option offered by EMI Health, which replaces Regence Expressions. See rates

» *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 pages 4-5 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 and Consumer Plus: 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?

If you have another health or dental plan through another source, you have a few different ways to look at your coverage:

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.

Opt-Out: If you have qualified medical or dental coverage in addition to your employer's health insurance, like through Tricare or your spouse's employer, you can Opt Out of medical and/or dental to get an increase in your paycheck. This option can save you from paying premiums for additional coverage, and provides more take home pay. (Medicare, Medicaid or Federal Marketplace plans are not qualified coverage)

Mountainland Technical College Benefits Guide

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OPEN ENROLLMENT: APRIL 24–MAY 17, 2023

Main Menu

Medical Plans

A STAR HSA Plan

Single Double Family

Your Annual Cost	Employer HSA Contribution	Medical Deductible (Medical & Pharmacy)	Out-of-Pocket Maximum (OOPM) (Medical & Pharmacy)
Single $142.74	Single $909.22	$1,500 / $3,000 / $3,000	$2,500 / $5,000 / $7,500
Double $294.84	Double $1,826.76		
Family $404.56	Family $1,918.54		

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 7.

B Traditional Plan

Your Annual Cost	Employer HSA Contribution	Medical Deductible (Medical & Pharmacy)	Out-of-Pocket Maximum (Medical & Pharmacy)
Single $723.84	Single $0	$350* / $700 / $700	$3,000* / $6,000 / $9,000
Double $1,492.14	Double $0		
Family $1,992.12	Family $0		

Plan Benefits

Review coverage and benefit details on page 10.

*per individual

» **CONSUMER PLUS** and **OPT-Out benefits** on next page

See Medical Plan Costs

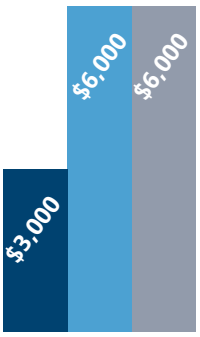
Medical Plans (continued)

C Consumer Plus Plan

Single Double Family

Your Annual Cost	Employer HSA Contribution
Single $0	Single $1,824.68
Double $0	Double $3,649.62
Family $0	Family $3,649.62

Medical Deductible
Medical & Pharmacy



Out-of-Pocket Maximum
Medical & Pharmacy

Plan Benefits

PEHP pays 70% coinsurance after deductible and you pay 30% coinsurance until you reach your OOPM.

Review coverage and benefit details on page 13.

D Opt-Out benefit

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

» **See Rates on Page 25 to see how much you receive**

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

» Income is subject to tax.

» Please do not cancel/terminate your current medical plan. You must enroll in the Opt-Out during Open Enrollment.

» **STAR HSA** and **TRADITIONAL** plans on previous page

See Medical Plan Costs

Plans at a Glance

A STAR HSA Plan

- You get money in an HSA for health-related expenses to offset a higher deductible. HSA funds carry over from year-to-year and grow tax-free. You never forfeit what you don't spend.
- If you're not eligible for an HSA, you can still receive the contribution amount in an employer-funded HRA account.
- 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.
- You have the option to add on a Flexible Spending Account (FLEX$) for qualified health expenses, which is funded through pre-tax payroll deductions.

C Consumer Plus Plan

- Essential benefit plan with catastrophic coverage.
- Similar to the STAR HSA Plan with a higher deductible, lower coinsurance, but fewer covered benefits and medications. See the Medical Grids and Consumer Plus Covered Drug List for what is covered.
- Your employer puts more money into an HSA or HRA for health-related expenses than the STAR HSA Plan to offset a higher deductible.
- You can participate in wellness programs, including Healthy Utah testing sessions; however, you're ***not*** eligible for rebates.

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

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 office surgeries, inpatient visits and Autism services*	30% after deductible	50% after deductible
Specialist Visits *Includes office surgeries, 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	Not covered

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	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*	30% after deductible	50% after deductible
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	Not covered	Not covered
Temporomandibular Joint Dysfunction	Not covered	Not covered

Medical Networks

DID YOU KNOW?

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

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

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

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Intermountain Layton Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

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

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

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
McKay-Dee Hospital

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

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

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital
Brigham City Community Hospital

Cache County
Cache Valley Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Lakeview Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

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

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

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

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

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Hospital

Weber County
Ogden Regional Medical Center

Non-Covered Providers

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

Dental Plans

Preferred
PEHP Dental network

- Small deductible that doesn't apply to preventive services
- Pays 80% of in-network rate for X-rays and cleanings
- Covers cleanings, preventive services, orthodontics, major services, etc.
- $1,500 annual limit per member, per plan year

Traditional
PEHP Dental network

- No deductible
- Pays 100% of in-network rate for X-rays and cleanings
- Covers cleanings, preventive services, orthodontics, major services, etc.
- $1,500 annual limit per member, per plan year

EMI Choice Indemnity

- Plan administered by EMI Health
- No deductible
- Pays 100% of in-network rate for X-rays and cleanings
- Covers cleanings, preventive services, orthodontics, major services, etc.
- Up to $2,000 annual limit per member, per plan year

Opt-Out Benefit

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

- To opt-out, go to the Dental section of online enrollment. Click "Change" then select "Opt-Out" from the available plans.
- Income is subject to tax

See Dental Plan Costs

IMPORTANT INFORMATION

Waiting Period ***(PEHP Preferred and Traditional plans)*** **»**
If you have been without dental coverage for more than 63 days, there is a waiting period of six months from the effective date of coverage for orthodontic, implant, and prosthodontic benefits. Waiting period may be waived with evidence of previous coverage. Learn more in the Dental Master Policy.

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP. Learn more in the Dental Master Policy.

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

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

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

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

*** AD** = After Deductible

PEHP Health & Benefits

Mountainland Technical College Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024
OPEN ENROLLMENT: APRIL 24–MAY 17, 2023

Main Menu

EMI HEALTH

More Choices More Coverage

Group: State of Utah
Plan: #1580
Choice Indemnity
Effective Date: 07/01/23
Benefit Year: Plan Year
Benefit Type: Contributory/Fully Insured

Services	In-Network Advantage Plus	In-Network Premier	Out-of-Network
Preventive Oral Exams, Cleanings, Sealants, X-rays, Fluoride	100%	100%	100% up to R&C
Basic Fillings, Space Maintainers, Oral Surgery	80%	80%	80% up to R&C
Major Crowns, Bridges, Prosthodontics, Implants	50%	50%	50% up to R&C
Orthodontics, Dependent Children (7-18)	50%	50%	50% up to R&C
Adults	25% discount	25% discount	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	NONE		
Deductibles	NONE		
Annual Maximum Per Person	$2,000	$1,500	$1,500
	All maximums are combined to the limits above.		

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

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

Provisions/Limitations/Exclusions

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

(800) 662-5851 | emihealth.com
5101 S. Commerce Drive, Murray, UT 84017

Underwritten and Administered by Educators Health Plans Life, Accident & Health
(EMI.MKTG.STATEOFUTAHDENTAL.0323.1238)

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

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)

PEHP Health & Benefits

Mountainland Technical College
Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024
OPEN ENROLLMENT: APRIL 24–MAY 17, 2023

Main Menu

Biweekly Medical Rates

	Employer (biweekly)	Employee pays biweekly	Total cost of plan
STAR HSA Plan (Summit or Advantage Network)			
Single	$268.79	$5.49	$274.28
Double	$556.04	$11.34	$567.38
Family	$762.34	$15.56	$777.90
Traditional Plan (Summit or Advantage Network)			
Single	$309.72	$27.84	$337.56
Double	$638.58	$57.39	$695.97
Family	$852.48	$76.62	$929.10
Consumer Plus Plan (Summit or Advantage Network)			
Single	$233.69	0	$233.69
Double	$486.23	0	$486.12
Family	$695.96	0	$695.96

Biweekly Vision Rates

	Employee
EyeMed Full	
Single	$3.46
Double	$5.56
Family	$7.64

	Employee
Opticare Full	
Single	$3.82
Double	$5.72
Family	$8.15

EyeMed, Eyewear Only	
Single	$3.01
Double	$4.69
Family	$6.37

Opticare, Eyewear Only	
Single	$2.97
Double	$4.37
Family	$5.90

Monthly Dental Rates

	Employer (biweekly)	Employee pays biweekly	Total cost of plan
PEHP Preferred Choice			
Single	$12.09	$1.35	$13.44
Double	$22.45	$2.50	$24.95
Family	$40.84	$4.56	$45.40
PEHP Traditional			
Single	$12.09	$2.44	$14.53
Double	$22.45	$4.50	$26.95
Family	$40.84	$8.23	$49.07
EMI Choice Indemnity			
Single	$12.09	$6.36	$18.45
Double	$22.45	$10.03	$32.48
Family	$40.84	$16.69	$57.53

Employer Contributions

Deposited into your HSA

STAR HSA	
Single	$909.22
Double	$1,826.76
Family	$1,918.54

Consumer Plus	
Single	$1,824.68
Double	$3,649.62
Family	$3,649.62

Opt-Out Benefit - biweekly

Added per paycheck if you waive your medical or dental plan

Medical	
Single	$76.93
Double	$153.85
Family	$153.85

Dental	
Single	$3.85
Double	$7.70
Family	$15.39

PEHP Health & Benefits

Mountainland Technical College

Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024

OPEN ENROLLMENT: APRIL 24–MAY 17, 2023

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

Mountainland Technical College

Benefits Guide

EFFECTIVE: JULY 1, 2023–JUNE 30, 2024

OPEN ENROLLMENT: APRIL 24–MAY 17, 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

Mountainland Technical College

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PEHP Cost Tools

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

You may even find cash back.

Learn more: www.pehp.org/save

PEHP Health & Benefits

PEHP Life & Accident

Group Term Life Coverage

EMPLOYEE BASIC COVERAGE

Your employer funds basic coverage at no charge to you.

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

LINE-OF-DUTY DEATH BENEFIT

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

ACCIDENTAL DEATH RIDER

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

EVIDENCE OF INSURABILITY

You must submit evidence of insurability if:

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

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

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

EMPLOYEE ADDITIONAL TERM COVERAGE

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

Monthly Rates	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 35	2.40	3.60	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 35 to 39	3.00	4.50	6.00	9.00	12.00	15.00	18.00	21.00	24.00	27.00	30.00
Age 40 to 44	4.20	6.30	8.40	12.60	16.80	21.00	25.20	29.40	33.60	37.80	42.00
Age 45 to 49	6.20	9.30	12.40	18.60	24.80	31.00	37.20	43.40	49.60	55.80	62.00
Age 50 to 54	9.20	13.80	18.40	27.60	36.80	46.00	55.20	64.40	73.60	82.80	92.00
Age 55 to 59	13.40	20.10	26.80	40.20	53.60	67.00	80.40	93.80	107.20	120.60	134.00
Age 60 to 64	19.80	29.70	39.60	59.40	79.20	99.00	118.80	138.60	158.40	178.20	198.00
Age 65 to 69	27.40	41.10	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes											
Coverage Amounts	27.40	41.10	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

PEHP Life & Accident

SPOUSE BASIC COVERAGE: Your employer funds $5,000 of spouse basic coverage at no charge to you.

SPOUSE ADDITIONAL TERM COVERAGE

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

Monthly Rates	25,000	50,000	75,000	100,000	150,000	200,000	250,000	300,000	350,000	400,000	450,000	500,000
Under age 35	1.20	2.40	3.60	4.80	7.20	9.60	12.00	14.40	16.80	19.20	21.60	24.00
Age 35 to 39	1.50	3.00	4.50	6.00	9.00	12.00	15.00	18.00	21.00	24.00	27.00	30.00
Age 40 to 44	2.10	4.20	6.30	8.40	12.60	16.80	21.00	25.20	29.40	33.60	37.80	42.00
Age 45 to 49	3.10	6.20	9.30	12.40	18.60	24.80	31.00	37.20	43.40	49.60	55.80	62.00
Age 50 to 54	4.60	9.20	13.80	18.40	27.60	36.80	46.00	55.20	64.40	73.60	82.80	92.00
Age 55 to 59	6.70	13.40	20.10	26.80	40.20	53.60	67.00	80.40	93.80	107.20	120.60	134.00
Age 60 to 64	9.90	19.80	29.70	39.60	59.40	79.20	99.00	118.80	138.60	158.40	178.20	198.00
Age 65 to 69	13.70	27.40	41.10	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
After age 69, rates remain constant and coverage changes												
Coverage Amounts	13.70	27.40	41.10	54.80	82.20	109.60	137.00	164.40	191.80	219.20	246.60	274.00
Age 70 to 74	12,500	25,000	37,500	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Age 75 and over	6,250	12,500	18,750	25,000	37,500	50,000	62,500	75,000	87,500	100,000	112,500	125,000

DEPENDENT CHILDREN COVERAGE

Your employer funds $5,000 of dependent children coverage at no charge to you. If you apply within 60 days of your hire date or the date of the child's birth, all amounts are guaranteed issue. After 60 days, a health statement will be required for each child. All eligible children will be covered at the same level for one premium. Children can be covered until married or age 26, whichever comes first.

CHILD BASIC COVERAGE: Your employer funds $5,000 at no cost to you.

Coverage Amount	5,000	10,000	15,000
Monthly cost	0.52	1.04	1.56

Accidental Death and Dismemberment (AD&D)

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

INDIVIDUAL PLAN

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

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

FAMILY PLAN

- Upgrade your individual AD&D plan to a family plan. Convert your employee-funded $50,000 individual plan to a $50,000 family plan at a cost of 0.64 per month.
- Select a coverage amount ranging from $25,000 to $200,000, and your spouse and dependents will be automatically covered as follows:
  - Your spouse will be insured for 40% of your coverage amount. If you have no dependent children, your spouse's coverage increases to 50% of yours;
  - Each dependent child is insured for 15% of your coverage amount. If you have no spouse, each eligible dependent child's coverage increases to 20% of yours.
- If injury to an insured person covered for this benefit results within one year of the date of the accident in any of the losses set forth, the plan will pay the sum specified opposite such loss, but the total amount payable for all such losses as a result of any one accident will not exceed the Principal Sum applicable to the insured person. The Principal Sum applicable to the insured person is the amount specified on the enrollment form.

PEHP Life & Accident

Accidental Death and Dismemberment (AD&D)

Additional AD&D Coverage and Cost

INDIVIDUAL PLAN		FAMILY PLAN
Coverage Amount	Monthly Cost	Monthly Cost
25,000	0.43	0.63
50,000	0.85	1.25
75,000	1.28	1.88
100,000	1.70	2.50
125,000	2.13	3.13
150,000	2.55	3.75
175,000	2.98	4.38
200,000	3.40	5.00
225,000	3.83	5.63
250,000	4.25	6.25

AD&D Payment Schedule

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

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

LIMITATIONS AND EXCLUSIONS

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

Master Policy

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

Accident Weekly Indemnity

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

Accident Weekly Indemnity Coverage and Cost

MONTHLY GROSS SALARY IN DOLLARS	MAXIMUM AMOUNT OF WEEKLY INDEMNITY	MONTHLY COST
250 and under	25	0.24
251 to 599	50	0.44
600 to 700	75	0.64
701 to 875	100	0.86
876 to 1,050	125	1.08
1,051 to 1,200	150	1.30
1,201 to 1,450	175	1.50
1,451 to 1,600	200	1.74
1,601 to 1,800	225	1.94
1,801 to 2,164	250	2.14
2,165 to 2,499	300	2.56
2,500 to 2,899	350	3.00
2,900 to 3,599	400	3.44
3,600 and over	500	4.28

Accident Medical Expense

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

Accident Medical Expense Coverage and Cost

MEDICAL EXPENSE COVERAGE	MONTHLY COST
$ 2,500	$ 1.00

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

MTech 5-16-22

PEHP Health & Benefits

Mountainland Technical College

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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 (Total from employer + employee)

Double/Family: $7,750 (Total from employer + employee)

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

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

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

Health Reimbursement Account (HRA)

If you choose a high deductible plan and you're not eligible for a health savings account (HSA), your employer contribution will be deposited into an HRA instead.

An HRA is an employer-paid fund that reimburses you for qualified medical expenses for you and your dependents. However, unlike with an HSA, you can't make personal contributions to an HRA. Funds rollover year-to-year, however, if you leave employment there is only a three-year period to spend the funds or they are forfeited. Check with your employer on how much and how often they contribute to the HRA.

For more information about FLEX$, HSAs, or HRAs, call 801-366-7503 or 800-753-7703.

PEHP Health & Benefits

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Mountainland Tech Benefits Guide

MOUNTAINLAND TECH

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 Mountainland Tech 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.

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