

2014 Medicare Benefits

Although Medicare offers excellent basic coverage, there are some medical and prescription costs that Medicare does not fully cover, or does not cover at all. In some situations these non-covered costs can be significant. PEHP's Medicare Supplement Medical and Medicare Part D approved Prescription Drug Plans allow you to purchase additional coverage for yourself and your spouse at very reasonable rates.

For calendar year 2014, PEHP will offer three Medicare Part D approved Prescription Drug Plans and three Medicare Supplemental Medical Plans. You can enroll in the plan(s) that will best meet your individual needs.

The prescription drug plans are the Basic, Basic Plus and Enhanced Plan. The difference between the prescription drug plans is the level of coverage for prescription drugs. Please refer to the "Prescription Benefits Medicare Part D" section for more details.

PEHP's Medicare Supplement Medical Plans are Plan 100, Plan 75 and Plan 50. The difference in the plans is the level of coinsurance you are responsible to pay. Please refer to the Medicare Supplement Medical Plans section for more details.





Medicare Supplement Medical Plan and Prescription Drug Benefits

Effective January 2014

Medicare Benefits

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This booklet is for informational purposes only and is intended to give a general overview of the Benefits available through PEHP's Medicare Supplement plans. This booklet is not a legal document and does not create or address all of the Benefits or rights and obligations of PEHP. *All* questions concerning rights and obligations regarding PEHP should be directed to the Public Employees Health Program.

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PEHP Medicare Supplement Medical Plans

Provides coverage for Medicare-eligible services. PEHP's Medicare Supplement plans – Plan 100, Plan 75 and Plan 50 – provide coverage for Medicare Part A and Medicare Part B deductibles, Medicare eligible copayments, Medicare Part B Excess Charges and Out of Country coverage. The difference in the plans is the level of coinsurance you are responsible to pay.

PEHP Medicare Prescription Drug Plans

PEHP offers three Medicare Part D approved prescription drug plans – the Basic, the Basic Plus and the Enhanced Plan, each with varying levels of coverage. Please see the “Medicare Part D Prescription Benefits” section for information on these plans.

Eligibility

To enroll in PEHP's Medicare Supplement Medical Plans, you must be enrolled in Medicare Part A and Part B. To enroll in PEHP's Medicare Part D Approved Prescription Drug Plans, you can be enrolled in either Medicare Part A or Part B.

During open enrollment you and your spouse can select the plan that best meets your individual needs. You can choose a pharmacy plan only, a Medicare Supplemental Medical plan only, or combine a pharmacy plan with the Medicare Supplemental Medical plan.

The PEHP Medicare Supplement Plan is available to:

1. Retired individuals age 65 and over who have earned service credit with Utah Retirement Systems (URS), are a participant in a URS Defined Contribution Plan, or who previously had PEHP medical coverage.
2. Individuals under the age of 65 who have Medicare coverage and are a member or a dependent of a member who has earned service credit with URS, or individuals who are participants in a URS Defined Contribution Plan.
3. Spouses and approved disabled dependents of those eligible under numbers 1 and 2.

When can you enroll in a PEHP Medicare Supplement plan?

1. When you first become eligible for Medicare.

You may enroll during the period that starts three months before and ends three months after you turn age 65. If you receive Medicare Benefits due to a disability, you may enroll three months before and after your 24th month of disability Benefits.

2. When your active group coverage terminates.

You have 63 days to enroll in PEHP's Medicare Supplement plans to avoid paying a late enrollment penalty on PEHP's Medicare Prescription Drug Plan.

3. During the annual open enrollment.

The open enrollment period for PEHP's Medicare Supplement plans is Oct. 15-Dec. 7.

It is your responsibility to enroll in Medicare Part A and Medicare Part B. Your effective date for PEHP's Medicare Supplement Plan will be the first day of the month following the date of PEHP's receipt of the enrollment form.

To avoid a lapse in coverage, PEHP must receive your enrollment form 30 days prior to the month that you turn age 65, or 30 days prior to the month that your active group coverage ends. If your enrollment form is received on time by PEHP, your coverage will be effective the first day of the month that you turn age 65 or the first day of the month your active group coverage terminates.

Enrollment

To enroll in PEHP's Medicare Supplement Medical or Medicare Part D approved Prescription Drug Plans, you must complete and mail an enrollment form to:

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

Enrollment Guidelines

Annual Coordinated Election Period

Oct. 15-Dec. 7 for each year.

Special Enrollment Periods

There are several Special Enrollment Periods (SEPs) that may affect when you can enroll in PEHP's Medicare Supplement Medical Plans and Medicare Part D approved prescription drug plans. A few examples are:

- » The beneficiary enters or leaves a skilled nursing facility.
- » The beneficiary enrolls in, or disenrolls from, a Medicare Advantage plan that has a prescription drug benefit.
- » If your plan no longer offers Medicare prescription drug coverage.

If a beneficiary doesn't meet the Special Enrollment criteria, he/she will be unable to re-enroll until Oct. 15, 2014, through Dec. 7, 2014, for coverage effective Jan. 1, 2015.

If you have questions regarding Special Enrollment Periods, please contact 1-800-MEDICARE, or visit www.medicare.gov.

Late Enrollment Penalty

This is imposed when a beneficiary fails to maintain creditable prescription drug coverage for a period of 63 days following the last day of an individual's enrollment in a creditable plan.

Disenrollment Guidelines – Medical

Voluntary Disenrollment

You may disenroll from PEHP's Medicare Supplement Medical Plan during one of the election periods by providing a signed, written notice to PEHP.

Disenrollment Guidelines – Drug

Voluntary Disenrollment

You may disenroll from a prescription drug plan during one of the election periods by doing the following:

- » Providing a signed, written notice to PEHP.
- » Giving a signed, written notice to any Social Security Administration or Railroad Retirement Board office.
- » Calling Medicare at 800-633-4227 (TTY/TDD 877-486-2048) to disenroll.

Required Involuntary Disenrollment for PEHP's Prescription Drug Plans

PEHP is required to disenroll an individual in the following cases:

- » The individual loses entitlement to Medicare.
- » The individual dies.
- » The prescription drug plan contract is terminated or the organization discontinues offering a plan in any portion of the area where it has previously been available.
- » The individual materially misrepresents information to the prescription drug plan organization regarding reimbursement for third-party coverage.
- » The individual enrolls in another Medicare Advantage Plan or Medicare Part D plan.

Involuntary Disenrollment for Disruptive Behavior

"Disruptive behavior" is behavior that substantially impairs the prescription drug plan's ability to arrange or provide care to the disruptive individual or other plan members.

Medicare Supplement Disclaimer

PEHP's Basic, Basic Plus and Enhanced prescription drug plans are creditable.

If you decide to join a different prescription drug plan or another Medicare supplement plan through another carrier, you must contact PEHP.

Medicare Premiums

Current applicable monthly premium for Medicare Parts A and B must be maintained with Social Security Administration. Premium for the PEHP Medicare Supplement Medical Plan and PEHP Medicare Part D approved Prescription drug plans will be billed monthly, or can be deducted from your monthly retirement check.

Medicare Subsidy Information

Beneficiaries interested in Medicare Part D subsidies may contact Express Scripts Customer Service at 800-590-2239 (TTY/TDD 800-716-3231), Medicare at 800-633-4227 (TTY/TDD 877-486-2048), the Social Security Administration at 800-772-1213 (TTY/TDD 800-325-0778), or your State Medicaid Office to see if you might qualify.

Limited-Income Subsidy Information

If you have qualified for additional assistance for your Medicare prescription drug plan costs, the amount of your premiums, and your prescription drug costs at the pharmacy will be less. Once you have enrolled in the Express Scripts Medicare Prescription Plan (PDP) for PEHP, Medicare will tell Express Scripts how much assistance you will be receiving. Express Scripts will then send you information on the amount you will pay. If you are not receiving additional assistance, you should contact the Social Security Administration at 800-772-1213 (TTY/TDD 800-325-0778) to see if you qualify.

How To File A Medical Claim

1. All claims must be submitted to Medicare first. Your physician must file the claim form with Medicare.
2. Medicare will send a Medicare Summary Notice form to you for each claim that is processed. Forward a copy of this form to PEHP for processing.
3. All assigned Benefits will be paid directly to the Provider unless PEHP is provided with a receipt from you.
4. It is your responsibility, not the Provider's, to make sure PEHP receives all of the Medicare Summary Notices for all services.
5. All claims must be submitted to PEHP within 36 months from the date of service.

Coordination Of Benefits

Auto Insurance/No-Fault

Any Benefits eligible for payment under automobile insurance including No-fault, Personal Injury Protection, or similar coverage required by law will be denied by PEHP, whether or not such coverage is actually in effect. All such auto insurance Benefits payable on your behalf will be considered, even if such coverage exceeds the statutory minimum required coverage. Written documentation is required to verify full Benefits paid by auto insurance.

Correction Of Payment In Error

PEHP shall have the right to pay to any organization making payments under other plans that should have been made under this plan, any amount necessary to satisfy the payment of claims under this plan. Amounts so paid by PEHP shall be considered Benefits paid under this plan, and PEHP shall be fully discharged from liability under this plan to the extent of such payments.

Multiple Coverages

PEHP follows the guidelines set forth by the National Association of Insurance Commissioners, Centers for Medicare and Medicaid Services, and the Utah Code Annotated §590-131-4 regarding the order of benefit determination. Please contact PEHP Customer Service for further clarification.

Here are answers to common questions you might have:

1. *Can I have PEHP's Medicare Supplement Plan and also have a Medigap policy?*

Yes, but only one of the plans may include Medicare Part D prescription drug coverage.

2. *Can I have PEHP's Medicare Supplement Prescription Drug Plan and also have an additional Medicare Part D prescription drug plan?*

No. You can only have one Medicare Part D prescription drug plan.

3. *Can I be covered under PEHP's Medicare Supplement Medical Plan and also be covered as a dependent on my spouse's active group coverage?*

Yes. PEHP's Medicare Supplement Medical Plan will coordinate with active group medical coverage.

4. *Can I be covered under PEHP's Medicare Part D prescription drug plan(s) and also be covered as a dependent on my spouse's active or retiree group coverage?*

Yes. The prescription drug Benefits included in the spouse's active or retiree group coverage and PEHP's Medicare Part D prescription drug plan(s) will coordinate, as long as your spouse's coverage is not another Medicare Prescription drug plan.

As noted above, PEHP's Medicare Supplement Medical Plan and PEHP's Medicare Part D Prescription Drug plans may not coordinate with all Medicare Supplemental plans.

When purchasing Medicare Medical or Medicare Part D Prescription Drug Supplement plans, DO NOT enroll in additional supplemental plans that will not provide additional coverage.

Contractual Reimbursement and Subrogation

Contractual Reimbursement

You agree to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If you do not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on your behalf.

In the event that Eligible Benefits are furnished to you for bodily injury or illness, you shall reimburse PEHP with respect to your right (to the extent of the value of the Benefits paid) to any claim for bodily injury or illness, regardless of whether you have been “made whole” or have been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for your claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP’s right to reimbursement is prior and superior to any other person or entity’s right to the claim for bodily injury or illness, including, but not limited to any attorney fees or costs you choose to incur in securing the amount of the claim.

Subrogation

You agree to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If you do not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on your behalf. You will cooperate fully with PEHP and will sign and deliver instruments and papers and do whatever else is necessary on PEHP’s behalf to secure such rights and to authorize PEHP to pursue these rights.

In the event that Eligible Benefits are furnished to you for bodily injury or illness, PEHP shall be and is hereby subrogated (substituted) with respect to your right (to the extent of the value of the Benefits paid) to any claim for bodily injury or

illness, regardless of whether you have been “made whole” or have been fully compensated for the injury or illness. PEHP shall have a lien against any amounts advanced or paid by PEHP for your claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP’s right to subrogation is prior and superior to any other person or entity’s right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs you choose to incur in securing the amount of the claim.

Acceptance Of Benefits And Notification

Acceptance of the Benefits hereunder shall constitute acceptance of PEHP’s right to reimbursement or subrogation rights as explained above.

Recoupment Of Benefit Payment

In the event you impair PEHP’s reimbursement or subrogation rights under this contract through failure to notify PEHP of potential liability, settling a claim with a responsible party without PEHP’s involvement, or otherwise, PEHP reserves the right to recover from you the value of all Benefits paid by PEHP on behalf of you resulting from the party’s acts or omissions.

No judgment against any party will be conclusive between you and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

Medical Benefits

Some Basic Things You Should Know About Medicare

There are some medical costs that Medicare does not cover fully, or does not cover at all. In addition to the applicable Medicare Part A and Part B deductibles, you will have to pay a share of the cost for Medicare-eligible services and all of the cost for services not eligible under Medicare.*

The PEHP Medicare Supplement Medical Plan will only consider payment on services that are eligible under Medicare and there are limitations on certain services. Contact Medicare for a complete list of eligible services. All services rendered must be medically necessary to be eligible. Custodial care and routine services are not eligible expenses under Medicare or the PEHP Medicare Supplement Medical Plan.

Your benefit payment is based on the Medicare allowable amount. You will be responsible for any excess charge above the Medicare allowable amount in addition to any deductibles or copayments.

What Medicare Part A *And* Part B Do Not Cover

Items and services that Medicare doesn't cover include, but aren't limited to, long-term care, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

***PLEASE NOTE:** Medicare Part B provides limited preventive coverage and preventive care screenings. Any questions regarding your Medicare Benefits, please contact Medicare. To find out if Medicare covers a service you need, visit www.medicare.gov, and select "Find Out What Medicare Covers," or call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

What are you responsible to pay?

Medicare Part B Excess Fees is the additional amount a health care provider may charge above the Medicare-approved amount. Most providers will accept the Medicare-approved amount as payment in full. Participating health care providers have signed an agreement to accept assignment for the Medicare-approved amount as payment in full for Medicare eligible services. Non-participating providers do not accept assignment for the Medicare-approved amount. You can be responsible for the amount above the Medicare approved amount they charge for Medicare eligible services. It is important for you to ask your health care provider if they accept the Medicare-approved amount as payment in full.

PEHP's plans help pay Medicare Part B Excess Fees

Your level of coverage for the Medicare Part B excess fees, depends on the PEHP Medicare Supplement Medical Plan you select. The Medicare-approved amount a non-participating provider can charge for Medicare eligible services is typically limited to a certain percentage. PEHP's payment for the Medicare Part B Excess fees is based on the limited percentage amount.

PEHP Medicare Supplement Medical Plan Out of Country Coverage

Medicare Parts A and B do not offer coverage for services while you are traveling outside the United States. However, your PEHP Medicare Supplement Medical Plan does offer coverage for these services. If you receive Urgent medical care in another country, allowable fees will be eligible billed charges. A copy of the original foreign claim must be submitted along with documentation proving payment. PEHP will determine the urgent or emergent status of each claim submitted for reimbursement. Please refer to the benefits grids for more information. **Out of country prescription drug claims are not eligible for reimbursement.**

Definitions

Benefit Period: The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Blood Benefits (Part A / Hospital): In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Blood Benefits (Part B / Outpatient): In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.

Coinsurance: An amount you may be required to pay as your share of the cost for Medicare eligible services after you pay any deductibles. Coinsurance is usually a percentage (e.g., 20%).

Copayment: An amount you may be required to pay as your share of the cost for a Medicare eligible medical service or supply. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Creditable Prescription Drug Coverage: On average at least as good or better than the Medicare minimum standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Critical Access Hospital: A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial Care: Nonskilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible: The amount you must pay for health care or prescriptions, before Medicare, your prescription drug plan, or your other insurance begins to pay.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Inpatient Rehabilitation Facility: A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution: A facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, such as an assisted living facility, or group home are not considered institutions for this purpose.

Life-threatening: The sudden and acute onset of an illness or injury where delay in treatment would jeopardize your life or cause permanent damage to your health such as, but not limited to, loss of heartbeat, loss of consciousness, cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life-threatening event will be made by PEHP on the basis of the final diagnosis and medical review of the records. PEHP reserves the right to solely determine whether or not a situation is Life-threatening.

Lifetime Reserve Days: In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-Term Care Hospital: Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically Necessary: Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare-approved Amount: This is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Part B Excess Charges: The additional amount a health care provider may charge above the Medicare-approved amount.

Skilled Nursing Facility (SNF) Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include, physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Urgent Condition: An acute health condition with a sudden, unexpected onset, which is not Life-threatening but which poses a danger to your health if not attended by a physician within 24 hours; e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

PEHP's Medicare Supplement Plans

PEHP's plans will only consider payment for services that are eligible under Medicare and there are limitations on certain services. Contact Medicare for a complete list of eligible services. PEHP's plans include coverage for Part B Excess Charges. Coverage is based on the plan you select. Part B Excess Charges, are charges from your physician above the Medicare-approved amount. Many physicians DO accept the Medicare-approved amount; however, some may not. All plans provide Benefits for out-of-country coverage.

PEHP's Medicare Supplement Medical (Plan 100)

This plan provides 100% coverage for the Medicare Part A and Part B deductibles and Medicare eligible copayments and coinsurances. It also provides 100% coverage for Medicare Part B excess fees.

PEHP's Medicare Supplement Medical (Plan 75)

This plan provides 75% coverage for the Medicare Part A and Part B deductibles, Medicare eligible copayments and coinsurances, and 75% coverage for Medicare Part B excess fees. This plan also provides the protection of an annual out-of-pocket maximum. Your cost-sharing portion of Medicare eligible covered services is applied to the **\$2,400 annual out-of-pocket maximum**. Once you reach the annual limit, the plan pays 100% of your Medicare eligible copayments and coinsurance for the remainder of the calendar year. All services noted with a ♦ in the grid apply to the annual out-of-pocket maximum limit. The out-of-pocket maximum does not apply to Part B Excess Fees and out-of-country coverage.

PEHP's Medicare Supplement Medical (Plan 50)

This plan provides 50% coverage for the Medicare Part A and Part B deductibles, Medicare eligible copayments and coinsurances, and 50% coverage for Medicare Part B excess fees. This plan also provides the protection of an annual out-of-pocket maximum. Your cost-sharing portion of Medicare eligible covered services is applied to the **\$4,800 annual out-of-pocket maximum**. Once you reach the annual limit, the plan pays 100% of your Medicare eligible copayments and coinsurance for the remainder of the calendar year. All services noted with a ♦ in the grid apply to the annual out-of-pocket maximum limit. The out-of-pocket maximum does not apply to Part B Excess Fees and out-of-country coverage.

PEHP's Medicare Supplement Plan (Plan 100)

| Medicare Part A | Medicare Pays | PEHP Plan Pays | You Pay |
|--|---|--|---------|
| Inpatient Hospitalization <i>Semi-private room and board, miscellaneous expenses</i> | | | |
| First 60 Days <i>Includes limited mental health</i> | All approved charges after the Medicare Deductible for the first 60 days | 100% of the Medicare Deductible for the first 60 days | Nothing |
| Days 61 to 90 | All approved charges, except for the Medicare Copayment for days 61 to 90 | 100% of the Medicare Copayment for days 61 to 90 | Nothing |
| 91 Days & Beyond <i>While using your 60 lifetime reserve days</i> | All approved charges, except for the Medicare Copayment per "lifetime reserve day" (Pg 15) for days 91 and beyond each benefit period | 100% of the Medicare Copayment per day for each "lifetime reserve day" and 90% of eligible expenses for days 151 and beyond. | Balance |
| Blood | | | |
| Whole Blood | 100% of Medicare-approved allowance after first three pints each calendar year | 100% of the first three pints of blood | Nothing |
| Skilled Nursing Facility <i>Short-term, non-custodial care only</i> <i>Confinement must follow a three-day stay in the hospital</i> | | | |
| First 20 Days | 100% of Medicare approved charges | Nothing | Nothing |
| Days 21 to 100 | 100% of approved charges, except for the Medicare Copayment per day | 100% of the Medicare Copayment per day | Nothing |
| Day 101 & Beyond | No Benefits are payable | No Benefits are payable | 100% |

PEHP's Medicare Supplement Plan (Plan 100)

| Medicare Part B | Medicare Pays | PEHP Plan Pays | You Pay |
|---|---|---|------------------------------------|
| Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i> | | | |
| Deductible | Not a covered benefit | 100% of the Medicare deductible | Nothing |
| Approved Charges | 80% of Medicare approved charges, after the Medicare deductible | 20% of Medicare approved charges, after the Medicare deductible | Nothing |
| Excess Charges <i>Above Medicare approved amounts</i> | Nothing | 100% of the Medicare Part B excess charges | Nothing |
| Mental Health Services <i>Outpatient treatment (Benefits may vary)</i> | | | |
| Diagnosis <i>of your condition</i> | 80% of Medicare approved charges, after the Medicare deductible | 20% of Medicare approved charges, after the Medicare deductible | Nothing |
| Urgent or Emergent Services Outside the United States | | | |
| Inpatient Hospital Room Charges <i>No day limit</i> | Not a covered benefit | 100% of billed charges, up to \$200 per day | Balance |
| Ancillary Hospital Charges <i>related to your inpatient stay</i> | Not a covered benefit | 100%, up to \$500 per day; 80% thereafter | Balance or 20% after \$500 per day |
| Outpatient Hospital Room Charges <i>Including ER</i> | Not a covered benefit | 80% of billed charges | Balance |
| Surgeon/Surgical Services | Not a covered benefit | 100% of billed charges | Nothing |
| Other Physician/ Professional Services <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i> | Not a covered benefit | 80% of billed charges | Balance |
| Ambulance | Not a covered benefit | 80% of billed charges | Balance |
| Prescription Drugs | Out-of-Country prescriptions are not eligible under the policy. | | |

PEHP's Medicare Supplement Plan (Plan 75)

| Medicare Part A | Medicare Pays | PEHP Plan Pays | You Pay |
|--|---|---|--|
| Inpatient Hospitalization <i>Semi-private room and board, miscellaneous expenses</i> | | | |
| First 60 Days <i>Includes limited mental health</i> | All approved charges after the Medicare Deductible for the first 60 days | 75% of the Medicare Deductible for the first 60 days | 25% of the Medicare Deductible ♦ |
| Days 61 to 90 | All approved charges, except for the Medicare Copayment for days 61 to 90 | 75% of the Medicare Copayment for days 61 to 90 | 25% of the Medicare Copayment ♦ |
| 91 Days & Beyond <i>While using your 60 lifetime reserve days</i> | All approved charges, except for the Medicare Copayment per "lifetime reserve day" (Pg 15) for days 91 and beyond each benefit period | 75% of the Medicare Copayment per day for each "lifetime reserve day" and 75% of eligible expenses for days 151 and beyond. | 25% of the Medicare Copayment per day for each "lifetime reserve day" and 25% of eligible expenses for days 151 and beyond ♦ |
| Blood | | | |
| Whole Blood | 100% of Medicare-approved allowance after first three pints each calendar year | 75% of the first three pints of blood | 25% of the first three pints of blood ♦ |
| Skilled Nursing Facility <i>Short-term, non-custodial care only</i> <i>Confinement must follow a three-day stay in the hospital</i> | | | |
| First 20 Days | 100% of Medicare approved charges | Nothing | Nothing |
| Days 21 to 100 | 100% of approved charges, except for the Medicare Copayment per day | 75% of the Medicare Copayment per day | 25% of the Medicare Copayment per day ♦ |
| Day 101 & Beyond | No Benefits are payable | No Benefits are payable | 100% |

♦ Applies to the annual out-of-pocket maximum limit (\$2,400).

PEHP's Medicare Supplement Plan (Plan 75)

| Medicare Part B | Medicare Pays | PEHP Plan Pays | You Pay |
|---|---|---|---|
| Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i> | | | |
| Deductible | Not a covered benefit | 75% of the Medicare deductible | 25% of the Deductible ♦ |
| Approved Charges | 80% of Medicare approved charges, after the Medicare deductible | 15% of Medicare approved charges, after the Medicare deductible | 5% of Medicare approved charges, after deductible ♦ |
| Excess Charges <i>Above Medicare approved amounts</i> | Nothing | 75% of the Medicare Part B excess charges | 25% of the Medicare Part B excess charges |
| Mental Health Services <i>Outpatient treatment (Benefits may vary)</i> | | | |
| Diagnosis <i>of your condition</i> | 80% of Medicare approved charges, after the Medicare deductible | 15% of Medicare approved charges, after the Medicare deductible | 5% of Medicare approved charges, after deductible ♦ |
| Urgent or Emergent Services Outside the United States | | | |
| Inpatient Hospital Room Charges <i>No day limit</i> | Not a covered benefit | 75% of billed charges, up to \$200 per day | Balance |
| Ancillary Hospital Charges <i>related to your inpatient stay</i> | Not a covered benefit | 75% of billed charges, up to \$500 per day | Balance or 25% after \$500 per day |
| Outpatient Hospital Room Charges <i>Including ER</i> | Not a covered benefit | 75% of billed charges | Balance |
| Surgeon/Surgical Services | Not a covered benefit | 75% of billed charges | Balance |
| Other Physician/ Professional Services <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i> | Not a covered benefit | 75% of billed charges | Balance |
| Ambulance | Not a covered benefit | 75% of billed charges | Balance |
| Prescription Drugs | Out-of-Country prescriptions are not eligible under the policy. | | |

♦ Applies to the annual out-of-pocket maximum limit (\$2,400).

PEHP's Medicare Supplement Plan (Plan 50)

| Medicare Part A | Medicare Pays | PEHP Plan Pays | You Pay |
|--|---|---|--|
| Inpatient Hospitalization <i>Semi-private room and board, miscellaneous expenses</i> | | | |
| First 60 Days <i>Includes limited mental health</i> | All approved charges after the Medicare Deductible for the first 60 days | 50% of the Medicare Deductible for the first 60 days | 50% of the Medicare Deductible ♦ |
| Days 61 to 90 | All approved charges, except for the Medicare Copayment for days 61 to 90 | 50% of the Medicare Copayment for days 61 to 90 | 50% of the Medicare Copayment ♦ |
| 91 Days & Beyond <i>While using your 60 lifetime reserve days</i> | All approved charges, except for the Medicare Copayment per "lifetime reserve day" (Pg 15) for days 91 and beyond each benefit period | 50% of the Medicare Copayment per day for each "lifetime reserve day" and 75% of eligible expenses for days 151 and beyond. | 50% of the Medicare Copayment per day for each "lifetime reserve day" and 25% of eligible expenses for days 151 and beyond ♦ |
| Blood | | | |
| Whole Blood | 100% of Medicare-approved allowance after first three pints each calendar year | 50% of the first three pints of blood | 50% of the first three pints of blood ♦ |
| Skilled Nursing Facility <i>Short-term, non-custodial care only</i> <i>Confinement must follow a three-day stay in the hospital</i> | | | |
| First 20 Days | 100% of Medicare approved charges | Nothing | Nothing |
| Days 21 to 100 | 100% of approved charges, except for the Medicare Copayment per day | 50% of the Medicare Copayment per day | 50% of the Medicare Copayment per day ♦ |
| Day 101 & Beyond | No Benefits are payable | No Benefits are payable | 100% |

♦ Applies to the annual out-of-pocket maximum limit (\$4,800).

PEHP's Medicare Supplement Plan (Plan 50)

| Medicare Part B | Medicare Pays | PEHP Plan Pays | You Pay |
|---|---|---|--|
| Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i> | | | |
| Deductible | Not a covered benefit | 50% of the Medicare deductible | 50% of deductible ♦ |
| Approved Charges | 80% of Medicare approved charges, after the Medicare deductible | 10% of Medicare approved charges, after the Medicare deductible | 10% of Medicare approved charges, after deductible ♦ |
| Excess Charges <i>Above Medicare approved amounts</i> | Nothing | 50% of the Medicare Part B excess charges | 50% of the Medicare Part B excess charges |
| Mental Health Services <i>Outpatient treatment (Benefits may vary)</i> | | | |
| Diagnosis <i>of your condition</i> | 80% of Medicare approved charges, after the Medicare deductible | 10% of Medicare approved charges, after the Medicare deductible | 10% of Medicare approved charges, after deductible ♦ |
| Urgent or Emergent Services Outside the United States | | | |
| Inpatient Hospital Room Charges <i>No day limit</i> | Not a covered benefit | 50% of billed charges, up to \$200 per day | Balance |
| Ancillary Hospital Charges <i>related to your inpatient stay</i> | Not a covered benefit | 50% of billed charges, up to \$500 per day | Balance, or 50% after \$500 per day |
| Outpatient Hospital Room Charges <i>Including ER</i> | Not a covered benefit | 50% of billed charges | Balance |
| Surgeon/Surgical Services | Not a covered benefit | 50% of billed charges | Balance |
| Other Physician/Professional Services <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i> | Not a covered benefit | 50% of billed charges | Balance |
| Ambulance | Not a covered benefit | 50% of billed charges | Balance |
| Prescription Drugs | Out-of-Country prescriptions are not eligible under the policy. | | |

♦ Applies to the annual out-of-pocket maximum limit (\$4,800).

Prescription Benefits

Plan Coverage

PEHP Medicare Prescription Drug Plans include coverage for:

- » Immunizations, except those covered under Medicare Part B preventive Benefits.
- » The Prescription Drug Benefit includes a List of Covered Drugs we call the “Drug List.” It tells which Part D prescription drugs are covered by Express Scripts Medicare. The brand-name and generic drugs on this list are selected by the plan with the help of a team of doctors and pharmacists and meet requirements set by Medicare.
- » Express Scripts may contact you if you are taking a drug that is not on the formulary. If the formulary changes, affected enrollees will be notified in writing by Express Scripts before the change is effective. PEHP offers three Medicare Part D approved prescription drug plans. The difference between the three plans is the level of coverage for prescription drugs.

The Express Scripts Medicare Prescription Plan for PEHP **does not** cover prescription drugs covered under Medicare Part B as prescribed and dispensed. Generally PEHP only covers drugs, vaccines, biologicals, and medical supplies that are covered under the Medicare Part D prescription drug benefit and included in the plans’ formulary.

Note: Participants in PEHP’s prescription drug plans will receive from Express Scripts a Benefit Overview and Evidence of Coverage booklet that provides detailed pharmacy benefit information. To get the most complete and current information about which drugs are covered, you can visit www.express-scripts.com or call Express Scripts Customer Service.

Beginning in 2014, you will have the choice of filling your retail prescriptions at a preferred network pharmacy or at a non-preferred network pharmacy.

A preferred pharmacy may offer lower cost-sharing than other pharmacies within our network. Please see the benefits grids for your cost-sharing amounts for each type of pharmacy.

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through our home delivery service. There is no charge for standard shipping.

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Customer Service for more information.

PEHP Basic Prescription Drug Plan

The Basic Plan has an up-front deductible and a gap in coverage during which you may be responsible for up to 100% of the cost of your prescriptions (except generic medications), up to a specified dollar amount*. PEHP will cover 28% of the cost for covered generic drugs and 2.5% of the covered brand name drugs, based on their negotiated discounted cost through the coverage gap.

PEHP Basic Plus Prescription Drug Plan

The Basic Plus Plan has an up-front deductible and a gap in coverage which provides coverage for generic medications only. You might be responsible for up to 100% of the cost of your prescriptions for preferred brand name, non-preferred and specialty drugs, up to a specified dollar amount.* PEHP will cover 2.5% of the covered brand name drugs, based on their negotiated discounted cost through the coverage gap.

**See page 26 for information on the Medicare Coverage Gap Discount Program.*

PEHP Enhanced Prescription Drug Plan

The PEHP Enhanced Prescription Drug Plan offers all of the prescription drug Benefits available under the Basic and Basic Plus plans, and provides Benefits through the coverage gap. The Benefits provided through the coverage gap include coverage of preferred generic, preferred brand name, non-preferred and specialty drugs.

Note: Due to healthcare reform, effective Jan. 1, 2014, you will receive a 50% manufacturer discount on your cost for brand name prescription drugs when your drug spend reaches \$2,850, unless you are receiving Medicare Extra help. The 50% manufacturer discount is applied before your PEHP benefit coinsurance/co-pay is calculated. The end result will be that you will pay no more than what you paid in the initial coverage stage.

Plan Administration

All of PEHP's Medicare prescription drug plans are administered by Express Scripts and are approved by Medicare.

Although Medicare is a Federal program, Express Scripts Medicare is available only to individuals who live in our plan service area. To stay a member of our plan, you must keep living in this service area. Our service area includes all 50 states, the District of Columbia, and Puerto Rico. If you plan to move out of the service area, please contact Customer Service and your benefit administrator.

If you choose either the Basic, Basic Plus or the Enhanced Prescription Plan, you will be enrolled in the Express Scripts Medicare for PEHP, offered through Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York.

This prescription drug section explains some of the features of the PEHP plans offered through Express Scripts. It does not list all covered drugs, limitations or exclusions. For a complete list of Benefits, or if you have questions, please call Express Scripts Customer Service at 800-590-2239, 24 hours a day, 7 days a week.

Express Scripts Medicare prescription plans for PEHP are available through participating retail pharmacies and the Express Scripts Pharmacy (mail-order service). For information regarding available pharmacies, please call Express Scripts Customer Service at 800-590-2239.

Medicare Coverage Gap

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the Coverage Gap and are not already receiving “Extra Help.” A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand-name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the Coverage Gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Express Scripts Customer Service.

How the Coverage Gap Works

As your yearly drug spending increases, your benefit changes

| | You've met your Deductible (\$310) | You've reached the Coverage Gap | You've reached your Catastrophic benefit |
|---|---|---|---|
| 0 to \$310 <i>Out-of-Pocket</i> You pay all expenses out-of-pocket | \$310.01 to \$2,850 <i>Total Drug Costs*</i> You pay according to the plan benefits | \$2,850.01 to \$4,550 You pay ... Basic: 72% for generic, 47.5% for brand name. Basic Plus: Copayment for generic, 47.5% for brand name** Enhanced: No coverage gap | \$4,550.01 and up <i>Out-of-Pocket</i> You pay according to the plan benefits |

* Total drug costs include what you pay, including the deductible, and what the plan pays.

** Plus a portion of the dispensing fee.

Common Questions About Medicare Prescription Drug Coverage

» *Where can I get my prescriptions?*

The Express Scripts Medicare Prescription Plan for PEHP includes a preferred network and non-preferred network of pharmacies. A preferred pharmacy may offer lower cost sharing than other pharmacies. You must use these pharmacy networks to receive plan Benefits. The Express Scripts Medicare Prescription Plan for PEHP may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in this network may change at any time. You may call Express Scripts Customer Service at 800-590-2239 for network pharmacy information, or for help finding a pharmacy. Prescriptions are also available through the Express Scripts Pharmacy for mail-order service.

» *Where can I get more detailed information about my drug plan?*

Express Scripts will send new members a “Welcome Kit” with your prescription benefit card. It will include Evidence of Coverage materials that will list the Medicare exclusions. The kit will also include a list of formulary drugs and a list of participating pharmacies as well as the summary of Benefits, which includes your costs. You may also call Express Scripts Customer Service at 800-590-2239, or you can download materials (including the current drug formulary) at www.express-scripts.com, after you register on the site.

» *What should I do if I have other insurance in addition to Medicare?*

PEHP’s Basic, Basic Plus and Enhanced Prescription Drug Plans provide Medicare approved prescription drug coverage. If you decide to enroll in a prescription drug plan offered by another company or a Medicare Advantage Plan, you need to notify PEHP.

If you or your spouse have employer group coverage, PEHP’s Basic, Basic Plus and Enhanced prescription drug plans **will** coordinate prescription drug coverage with the employer group prescription drug coverage. Contact PEHP Customer Service at 800-765-7347 for information before you enroll in the Basic, Basic Plus or Enhanced plan if employer group coverage is available to you.

» *What is a Medication Therapy Management program?*

A Medication Therapy Management (MTM) program is a benefit that is mandated by Medicare and administered by Express Scripts. You may be identified to participate in a program designed for your specific health and pharmacy needs. This program is voluntary, but it is recommended that you take full advantage of this covered benefit

if you are selected. If you have questions concerning Express Scripts' MTM Program, contact Express Scripts Customer Service at 800-590-2239.

» *How can I get help with drug plan costs?*

Medicare beneficiaries with low or limited income and resources may qualify for additional assistance. If you qualify, your Medicare prescription drug plan costs, the amount of your premiums, and your prescription drug costs at the pharmacy will be less. Once you have enrolled in the Express Scripts Medicare Prescription Plan for PEHP, Medicare will notify Express Scripts, who will then send you information on the amount you will pay for your premiums, deductible and co-pays. To see if you might qualify for additional assistance, contact the Social Security Administration at 800-772-1213 (TTY/TDD 800-325-0778).

» *What if my prescription claim is denied?*

If your physician prescribes a drug that is not on the formulary, you may ask Express Scripts to make a coverage exception. You always have the right to appeal and ask Express Scripts to review a claim that was denied.

» *What happens if my drugs are removed from the formulary list?*

If the plan removes drugs from the formulary, or adds prior authorizations, quantity limits, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year.

However, if a brand name drug is replaced with a new generic drug, or the formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. You will be notified of the change at least 60 days before the date that the change becomes effective.

» *How does my enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?*

If your drug would be covered by Medicare Part A or Part B, it can't be covered by Medicare Part D even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan (Medicare Part D) in other cases, but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or Express Scripts for the drug in question.

Mandated Medicare Drug Exclusions

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- » Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- » Our Plan cannot cover a drug purchased outside the United States and its territories.
- » Our Plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label, as approved by the Food and Drug Administration.
 - › Generally, coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI, or its successor. If the use is not supported by any of these reference books, then our Plan cannot cover its off-label use.

Also, by law, these categories of drugs are not covered by Medicare drug plans unless we offer enhanced drug coverage, for which you may be charged an additional premium:

- » Non-prescription drugs (also called over-the-counter drugs)
- » Drugs when used to promote fertility
- » Drugs when used for the relief of cough or cold symptoms
- » Drugs when used for cosmetic purposes or to promote hair growth
- » Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- » Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- » Drugs when used for treatment of anorexia, weight loss, or weight gain
- » Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- » Barbiturates and benzodiazepines

Drug Utilization Management

For certain prescription drugs, there are additional requirements for coverage or limits on your coverage. These requirements and limits are to ensure that you use these drugs in the most effective way and also help to control drug plan costs. A team of medical providers developed these requirements and limits to help provide you with quality drug coverage. Some examples of utilization management tools include:

» **Prior Authorization**

Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. If you don’t receive this approval, the Express Scripts Medicare Prescription Plan (PDP) for PEHP may not pay for your prescription.

» **Quantity Limits**

A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

» **Generic Drug**

A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

» **Generic Substitution**

When there is a generic version of a brand name drug available, our participating pharmacies will automatically give you the generic version, unless your doctor has specified that you must take the brand name drug.

Coverage Limits And Appeals

Some of the drugs covered by the Express Scripts Medicare Prescription Plan for PEHP have coverage limits. You can find out if your drug is subject to these additional requirements or limits by looking on the drug formulary list. If your drug is subject to drug utilization requirements, you or your doctor can ask Express Scripts to make an exception to the coverage rules.

If you have a prescription for a drug with a coverage limit, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will also give you a toll-free number to call.

If you are told there is a coverage limit, more information may be needed to see if your prescription meets the Express Scripts Medicare Prescription Plan (PDP) for PEHP coverage conditions. Express Scripts will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time allowed under your coverage. If coverage is denied, the letter will provide an explanation and information on how to submit an appeal.

Service And Complaints

If you are not satisfied with the service received from Express Scripts, you may file a complaint. Use any of the following ways to address problems you are having with service from the Express Scripts Medicare Prescription Plan (PDP) for PEHP network pharmacies, Express Scripts Pharmacy, or the Express Scripts Customer Service Department:

- » Call Express Scripts Customer Service at 800-590-2239 (TTY/TDD 800-716-3231).
- » Complete a Service and Complaint Form on the Express Scripts website:
www.express-scripts.com.
- » Write to the Express Scripts Service and Complaints Department:
Express Scripts Health Solutions, Inc.
Attn: Service Grievance Resolution Team
P.O. Box 639405
Irving, Texas 75063

If you need assistance or more information on filing a complaint, please call Express Scripts Service and Complaints Department at 800-590-2239 (TTY/TDD 800-716-3231). Representatives are available 24 hours a day, 7 days a week.

Basic Drug Plan | Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,850.

| Tier | Retail 31-day Supply | Retail 60-day Supply | Retail 90-day Supply | Mail Order 90-day Supply |
|---|--|---|---|---|
| Tier 1 Generic Drugs Preferred Pharmacy | 10% coinsurance \$5 minimum/ no maximum | 10% coinsurance \$7 minimum/ no maximum | 10% coinsurance \$7 minimum/ no maximum | 10% coinsurance \$5 minimum/ \$75 maximum |
| Non-Preferred Pharmacy | 10% coinsurance \$10 minimum/ no maximum | 10% coinsurance \$12 minimum/ no maximum | 10% coinsurance \$12 minimum/ no maximum | |
| Tier 2 Preferred Brand Drugs Preferred Pharmacy | 25% coinsurance \$25 minimum/ no maximum | 25% coinsurance \$50 minimum/ no maximum | 25% coinsurance \$75 minimum/ no maximum | 25% coinsurance \$50 minimum/ \$100 maximum |
| Non-Preferred Pharmacy | 25% coinsurance \$30 minimum/ no maximum | 25% coinsurance \$55 minimum/ no maximum | 25% coinsurance \$80 minimum/ no maximum | |
| Tier 3 Non-Preferred Brand Drugs Preferred Pharmacy | 50% coinsurance \$50 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum | 50% coinsurance \$150 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum |
| Non-Preferred Pharmacy | 50% coinsurance \$55 minimum/ no maximum | 50% coinsurance \$105 minimum/ no maximum | 50% coinsurance \$155 minimum/ no maximum | |
| Tier 4 Specialty Drugs <i>Preferred and Non-Preferred Pharmacy</i> | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ maximums: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$375 |

Basic Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,850, you will pay the following until your yearly out-of-pocket drug costs reach \$4,550.

| | |
|---------------|--|
| Brand Drugs | 47.5% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference.) |
| Generic Drugs | 72% of the plan's costs for all covered generic drugs. |

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,550, you will pay the greater of 5% coinsurance or the following.

| | | | | |
|------------|---|----------------------------------|-------------------------------|---|
| Retail | » a \$2.55 copayment for covered generic drugs (including brand drugs treated as generics) » a \$6.35 copayment for all other covered drugs. | | | |
| Mail Order | Generic Drugs (including brand drugs treated as generics): | Preferred Brand Drugs: | Non-Preferred Brand Drugs: | Specialty Tier Drugs: |
| | \$2.55 minimum/ \$75 maximum | \$6.35 minimum/ \$100 maximum | \$6.35 minimum/ no maximum | \$2.55 minimum for generics and \$6.35 minimum for brand drugs, with maximums of: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$375 |

Basic Plus Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,850.

| Tier | Retail 31-day Supply | Retail 60-day Supply | Retail 90-day Supply | Mail Order 90-day Supply |
|---|--|---|---|---|
| Tier 1 Generic Drugs Preferred Pharmacy | \$10 copayment | \$20 copayment | \$30 copayment | \$20 copayment |
| Non-Preferred Pharmacy | \$15 copayment | \$25 copayment | \$35 copayment | |
| Tier 2 Preferred Brand Drugs Preferred Pharmacy | 25% coinsurance \$25 minimum/ \$50 maximum | 25% coinsurance \$50 minimum/ \$100 maximum | 25% coinsurance \$75 minimum/ \$150 maximum | 25% coinsurance \$50 minimum/ \$100 maximum |
| Non-Preferred Pharmacy | 25% coinsurance \$30 minimum/ \$50 maximum | 25% coinsurance \$55 minimum/ \$100 maximum | 25% coinsurance \$80 minimum/ \$150 maximum | |
| Tier 3 Non-Preferred Brand Drugs | 50% coinsurance \$50 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum | 50% coinsurance \$150 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum |
| Non-Preferred Pharmacy | 50% coinsurance \$55 minimum/ no maximum | 50% coinsurance \$105 minimum/ no maximum | 50% coinsurance \$155 minimum/ no maximum | |
| Tier 4 Specialty Drugs <i>Preferred and Non-Preferred Pharmacy</i> | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ maximums: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$450 |

Basic Plus Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,850, you will pay the following until your yearly out-of-pocket drug costs reach \$4,550.

| | |
|---------------|--|
| Brand Drugs | 47.5% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference.) |
| Generic Drugs | The same copayment/coinsurance as in the Initial Coverage stage for Tier 1 Generic Drugs and 72% of the plan's costs for all other covered generic drugs. |

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,550, you will pay the greater of 5% coinsurance or the following.

| | | | | |
|------------|--|----------------------------------|-------------------------------|--|
| Retail | <p>» a \$2.55 copayment for covered generic drugs (including brand drugs treated as generics)</p> <p>» a \$6.35 copayment for all other covered drugs.</p> | | | |
| Mail Order | Generic Drugs (including brand drugs treated as generics): | Preferred Brand Drugs: | Non-Preferred Brand Drugs: | Specialty Tier Drugs: |
| | \$2.55 minimum/ \$75 maximum | \$6.35 minimum/ \$100 maximum | \$6.35 minimum/ no maximum | <p>\$2.55 minimum for generics and \$6.35 minimum for brand drugs, with maximums of:</p> <p>0-31 days: \$150 32-60 days: \$300 61-90 days: \$450</p> |

Enhanced Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,850.

| Tier | Retail 31-day Supply | Retail 60-day Supply | Retail 90-day Supply | Mail Order 90-day Supply |
|--|--|---|---|---|
| Tier 1 Generic Drugs Preferred Pharmacy | \$10 copayment | \$20 copayment | \$30 copayment | \$20 copayment |
| Non-Preferred Pharmacy | \$15 copayment | \$25 copayment | \$35 copayment | |
| Tier 2 Preferred Brand Drugs Preferred Pharmacy | 25% coinsurance \$25 minimum/ \$50 maximum | 25% coinsurance \$50 minimum/ \$100 maximum | 25% coinsurance \$75 minimum/ \$150 maximum | 25% coinsurance \$50 minimum/ \$100 maximum |
| Non-Preferred Pharmacy | 25% coinsurance \$30 minimum/ \$50 maximum | 25% coinsurance \$55 minimum/ \$100 maximum | 25% coinsurance \$80 minimum/ \$150 maximum | |
| Tier 3 Non-Preferred Brand Drugs | 50% coinsurance \$50 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum | 50% coinsurance \$150 minimum/ no maximum | 50% coinsurance \$100 minimum/ no maximum |
| Non-Preferred Pharmacy | 50% coinsurance \$55 minimum/ no maximum | 50% coinsurance \$105 minimum/ no maximum | 50% coinsurance \$155 minimum/ no maximum | |
| Tier 4 Specialty Drugs <i>Preferred and Non-Preferred Pharmacy</i> | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ no maximum | 25% coinsurance no minimum/ maximums: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$450 |

Enhanced Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$310 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,850, you will pay no more than the cost-sharing amounts in the Initial Coverage stage until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,550, you will pay the greater of 5% coinsurance or the following.

| | | | | |
|------------|---|----------------------------------|-------------------------------|---|
| Retail | » a \$2.55 copayment for covered generic drugs (including brand drugs treated as generics) » a \$6.35 copayment for all other covered drugs. | | | |
| Mail Order | Generic Drugs (including brand drugs treated as generics): | Preferred Brand Drugs: | Non-Preferred Brand Drugs: | Specialty Tier Drugs: |
| | \$2.55 minimum/ \$75 maximum | \$6.35 minimum/ \$100 maximum | \$6.35 minimum/ no maximum | \$2.55 minimum for generics and \$6.35 minimum for brand drugs, with maximums of: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$450 |

PEHP's Discount Dental Plan

Value-Added Dental Plan

The discount dental plan is available to individuals that are enrolled in one of PEHP's Medicare Supplement Medical Plans. This is a valued added dental plan, there is no monthly cost.

These discounts are only available when services are rendered by a licensed dentist that is a contracted provider with PEHP. To view a list of contracted dental providers, please visit www.pehp.org. You can also contact PEHP's customer service department. They can assist you in finding a contracted provider or mail you a provider directory.

The average savings you will receive when services are performed by a contracted dentist is 25% off the billed amount. Some examples are:

| Dental Code | Procedure | Your Cost |
|--------------------|--|------------------|
| 1110 | Adult Routine Dental Cleaning | \$44.34 |
| 0120 | Periodic adult oral examination | \$21.00 |
| 0274 | Dental bitewings four films | \$27.43 |
| 2391 | Resin based composite one surface posterior filling | \$78.53 |
| 2392 | Resin based composite two surfaces posterior filling | \$127.98 |
| 2393 | Resin based composite three surfaces posterior filling | \$127.98 |
| 3330 | Root canal therapy on a molar (excludes final restoration) | \$406.02 |
| 2750 | Crown – porcelain fused to high noble metal | \$566.59 |
| 2752 | Crown – porcelain fused to noble metal | \$540.22 |
| 7240 | Removal of complete bony impacted tooth | \$241.68 |
| 2740 | Porcelain – ceramic crown build up | \$574.54 |
| 6010 | Surgical placement of implant post | \$1,171.17 |

Discounts are only available when services are provided by a licensed contracted provider. Payment for services is due at the time of service.

Discount Dental Plan Features

- » No waiting periods
- » No plan limits
- » No deductibles
- » No monthly cost to join the plan

There are some services that are not a benefit of the plan.

Some of those services are:

- » Orthodontia
- » Cosmetic Surgery
- » TMJ
- » Services that are performed by a non-contracted provider.

To access services, simply show your PEHP Medicare Supplement ID Card at the time of service. You will also receive an explanation of Benefits from PEHP. This will advise you on the amount you are responsible to pay.

Contact Information

PEHP

*560 East 200 South
Salt Lake City, UT 84102-2004*

Customer Service

(Benefits and Claims):

801-366-7555

or toll-free 800-765-7347

Premium Billing:

801-366-7574

or toll-free 800-765-7347

Website: www.pehp.org

Prescription Benefits

(Medicare Part D)

Express Scripts Health Solutions, Inc.

P.O. Box 14570

Lexington, KY 40512

Customer Service:

Toll-free 800-590-2239

(TTY/TDD 800-716-3231)

Website: www.express-scripts.com

Noridian

Medicare Part A

P.O. Box 6724

Fargo, ND 58108-6724

Customer Service:

Toll Free 877-908-8437

Medicare Part B

P.O. Box 6725

Fargo, ND 58108-6725

Customer Service:

Toll Free 877-908-8431

Website:

www.noridianmedicare.com

*This website also includes a list of
physicians who accept Medicare
assignment.*

Social Security Administration

Toll-free 800-772-1213

(TTY/TDD 800-325-0778)

Website: www.ssa.gov

Medicare Administration

Toll-free 800-633-4227

(TTY/TDD 877-486-2048)

Website: www.medicare.gov

CREDITABLE COVERAGE DISCLOSURE NOTICE
MEDICARE D PRESCRIPTION DRUG COVERAGE
PEHP MEDICARE PRESCRIPTION / DRUG COVERAGE

Dear PEHP Medicare Supplement members and eligible members:

Please read this notice carefully and keep it with your records for future reference.

This notice has information about your current prescription drug coverage through PEHP.

Medicare requires PEHP to provide this notice to inform participants our Medical Plan's Prescription Drug Benefits are Creditable.

Creditable prescription drug coverage is on average at least as good or better than the 2014 Medicare minimum standard prescription drug coverage.

Creditable coverage is important to you because potential Medicare Part D enrollees who are not covered under a creditable prescription drug plan will likely pay a higher premium when they enroll with a Medicare Prescription Drug Plan.

Medicare requires PEHP to provide this notice, to inform participants of our Plan's prescription drug creditable coverage status, at the following times:

- » Prior to October 15 of each year;
- » Before the initial enrollment period for Medicare Part D prescription drug plans;
- » Before the effective date of enrollment in a PEHP Medicare Supplement Plan;
- » When drug coverage ends or the status of creditable coverage changes; and
- » Upon your request.

The Importance of Creditable Prescription Drug Coverage

Creditable coverage is important to you because potential Medicare Part D enrollees who are not covered under a creditable prescription drug plan will

likely pay a higher premium when they enroll with a Medicare Prescription Drug Plan.

Under Medicare rules, if you drop or lose your creditable prescription drug coverage and/or you go 63 days or longer without prescription drug coverage that is at least as good as the 2014 Medicare minimum standard, your monthly premium for the Medicare Part D prescription drug coverage will be more.

The late enrollment penalty is calculated by multiplying 1% of the national base beneficiary premium for Medicare Part D Prescription Drug plans, (\$31.17 in 2013), by the number of full months you were eligible but didn't join a Medicare Part D Prescription Drug plan and/or went without creditable prescription drug coverage. The final amount is rounded to the nearest \$0.10 and added to your Medicare Part D Prescription Drug plan monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare Part D Prescription Drug Plan.

Example: You went without creditable prescription drug coverage from July 2010 – December 2012, your penalty in 2013 is 30% (1% for each of the 30 months without creditable prescription drug coverage). The calculation: .30 (30% penalty) x \$31.17 (2013 national base beneficiary premium) = \$9.35. Rounded to nearest \$0.10, you will be charged an additional \$9.40 each month in addition to your Medicare Part D Prescription Drug plan's monthly premium. However, if Medicare Part D eligible individuals are covered under a plan that is providing creditable prescription drug coverage, and there is no break-in-coverage, you will not be assessed a late enrollment penalty if you choose to enroll in Medicare Part D drug coverage at a later date.

PEHP's Creditable Prescription Drug Plans

PEHP'S 2014 Medicare Prescription Drug Plans Are Creditable.

The following PEHP active employee, early retiree, and COBRA Medical Plans include prescription drug benefits that are CREDITABLE.

- » All Plans using the Summit, Advantage, and Preferred networks, including STAR Plans (Qualified High Deductible Health Plans).

PEHP's Non-Creditable Prescription Drug Plans

The following PEHP active employee, early retiree, and COBRA Medical Plans include prescription drug benefits that are NOT CREDITABLE.

- » All Basic Care Plus High Deductible Medical Plans
- » All Utah Basic Plus Medical Plans

Jordan School District members contact your plan administrator to see if your prescription drug plan is creditable.

Enrolling in PEHP's Medicare Plans

If you want coverage through one of PEHP's Medicare Supplement Medical Plans you **must** be enrolled in Medicare Part A and Part B. If you want coverage through one of PEHP's Medicare Part D prescription Drug plans you must be enrolled in Medicare Part A or Medicare Part B.

When You Can Enroll:

- » Three months before age 65, the month you turn age 65 through the three months after age 65.
- » During the 7-month period that starts 3 months before your 25th month of disability and ends 3 months after your 25th month of disability.
- » Within 63 days of the date your active group coverage ends.
- » At Open Enrollment for PEHP's Medicare Supplement Medical and Medicare Prescription drug plans, October 15 through December 7. Benefits effective January 1.
- » Eligible enrollments outside of Open Enrollment, your effective date will be the first day of the month following the date of PEHP's receipt of the enrollment form.

To avoid a lapse in coverage, PEHP must receive your enrollment form 30 days prior to the month that you turn 65 or 30 days prior to the month that your group coverage ends. If your enrollment form is received timely by PEHP, your coverage will be effective the first day of the month that you turn age 65 or the first day of the month your active group coverage terminates.

Other times you can enroll in a Medicare Prescription Drug Plan

- » If you move out of the service area of the plan you are enrolled in;
- » If you have both Medicare and Medicaid;
- » If you live in, or move into or out of an institution (like a nursing home);
- » If you lose creditable prescription drug coverage; or
- » Anytime, you qualify for Medicare Extra Help.

It is your responsibility to enroll in Medicare Part A and Medicare Part B.

What Happens To Your Current Prescription Drug Coverage If You Decided to Join a Medicare Prescription Drug Plan?

If you and your spouse are currently enrolled in an employer group plan or an employer group retiree plan it may impact other benefits such as medical coverage. Please contact your group benefits administrator for more information before enrolling in a Medicare Prescription Drug Plan.

Questions Regarding Medicare Part D

Additional information regarding the specific Medicare Part D plans is available in the “Medicare and You 2014” handbook. You can also visit:

- » Visit www.medicare.gov for personalized help
- » Call 1-800-MEDICARE (800-633-4227) TTY users should call 877-486-2048

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

Contact PEHP at 801-366-7555 or 800-765-7347 for further information.



Notice of Privacy Practices for Protected Health Information

effective August 31, 2013

Public Employees Health Program (PEHP) our business associates and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we have adopted the following privacy principles and information practices. PEHP is required by law to maintain the privacy of your protected health information, and to provide you with this notice which describes PEHP's legal duties and privacy practices. Our practices apply to current and former members.

It is the policy of PEHP to treat all member information with the utmost discretion and confidentiality, and to prohibit improper release in accordance with the confidentiality requirements of state and federal laws and regulations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Types of Personal Information PEHP collects

PEHP collects a variety of personal information to administer a member's health, life, and long term disability coverage. Some of the information members provide on enrollment forms, surveys, and correspondence includes: address, Social Security number, and dependent information. PEHP also receives personal information (such as eligibility and claims information) through transactions with our affiliates, members, employers, other insurers, and health care providers. This information is retained after a member's coverage ends. PEHP limits the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

Disclosure of your protected health information within PEHP is on a need-to-know basis. All employees are required to sign a confidentiality agreement as a condition of employment, whereby they agree not to request, use, or disclose the protected health information of PEHP members unless necessary to perform their job.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy,
- Better understand who, what, when, where, and why others may access your health information,
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that

compiled it, the information belongs to you. You have the rights as outlined in Title 45 of the Code of Federal Regulations, Parts 160 & 164:

- Request a restriction on certain uses and disclosures of your information, though PEHP is not required to agree with your requested restriction.
- Obtain a paper copy of the notice of information practices upon request (although we have posted a copy on our web site, you have a right to a hard copy upon request.)
- Inspect and obtain a copy of your health record.
- Amend your health records.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.
- That occurred before April 14, 2003.

PEHP must provide the accounting within 60 days of receipt of your written request.

The accounting must include:

- Date of each disclosure
- Name and address of the organization or person who received the protected health information
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

Examples of Uses and Disclosures of Protected Health Information

PEHP will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

Though PEHP does not provide direct treatment to individuals, we do use the health information described above for utilization and medical review purposes. These review procedures facilitate the payment and/or denial of payment of health care services you may have received. All payments or denial decisions are made in accordance with the individual plan provisions and limitations as described in the applicable PEHP Master Policies.

PEHP will use your health information for payment.

For example: A bill for health care services you received may be sent to you or PEHP. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

PEHP will use your health information for health operations.

For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess

the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. PEHP will only do so after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

There are certain uses and disclosures of your health information which are required or permitted by Federal Regulations and do not require your consent or authorization.

Examples include:

Public Health.

As required by law, PEHP may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Business Associates.

There are some services provided in our organization through contacts with business associates. When such services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Food and Drug Administration (FDA).

PEHP may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation.

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Correctional Institution.

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement.

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Our Responsibilities Under the Federal Privacy Standard

PEHP is required to:

- Maintain the privacy of your health information, as required by law, and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information
- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality
- Implement a policy to discipline those who violate PEHP's privacy, confidentiality policies.
- Mitigate (lessen the harm of) any breach of privacy, confidentiality.
- To notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should we change our Notice of Privacy Practices you will be notified.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law. PEHP is prohibited from using or disclosing the genetic information of an individual for underwriting purposes.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. Other uses and disclosures not described in this notice of privacy practices require your written authorization.

Inspecting Your Health Information

If you wish to inspect or obtain copies of your protected health information, please send your written request to PEHP, Customer Service, 560 East 200 South, Salt Lake City, UT 84102-2099. We will arrange a convenient time for you to visit our office for inspection. We will provide copies to you for a nominal fee. If your request for inspection or copying of your protected health information is denied, we will provide you with the specific reasons and an opportunity to appeal our decision.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the PEHP Customer Service Department at (801) 366-7555 or (800) 955-7347.

If you believe your privacy rights have been violated, you can file a written complaint with our Chief Privacy Officer at:

ATTN: PEHP Chief Privacy Officer
560 East 200 South
Salt Lake City, UT 84102-2099.

Alternately, you may file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.



560 East 200 South, Salt Lake City, UT 84102-2004
Customer Service: 801-366-7555 / Toll Free 800-765-7347

Medicare Supplement Plan Enrollment and Record Card

**Please note: Both Social Security Number and
Medicare ID Number are required
for each applicant.**

Reason for enrollment change _____

Retiree Information

Spouse Information on Reverse

| | | | |
|---|---|---|-----------------------|
| NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD | | SOCIAL SECURITY NUMBER _____-_____-_____ | BIRTH DATE (mm/dd/yy) |
| GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed | MEDICARE ID NUMBER _____-_____-_____ | HOME PHONE |
| HOME ADDRESS | | CITY/STATE/ZIP | EMAIL ADDRESS |

CURRENT MEDICARE COVERAGE

***Note: You must be enrolled in Medicare Parts A and B to enroll in any PEHP Medicare Supplement (medical) plan.**

Do you currently have a Medicare Supplement or Medicare Advantage Plan? ☐ Yes ☐ No

☐ Part A ☐ Part B

If yes, provide company name _____ Termination Date _____

PLAN SELECTION

| MEDICAL | | PHARMACY |
|---|--|--|
| <input type="checkbox"/> PEHP's Medicare Supplement Medical Plan 100 (Includes Discount Dental Plan) | You may choose a Medical Plan only, or a Pharmacy Plan only, or a combination of both Medical and Pharmacy. | <input type="checkbox"/> Basic Pharmacy |
| <input type="checkbox"/> PEHP's Medicare Supplement Medical Plan 75 (Includes Discount Dental Plan) | | <input type="checkbox"/> Basic Plus Pharmacy |
| <input type="checkbox"/> PEHP's Medicare Supplement Medical Plan 50 (Includes Discount Dental Plan) | | <input type="checkbox"/> Enhanced Pharmacy |

☐ No Coverage / Terminate Coverage

I represent that the above information is true and correct. I understand any materially incorrect, or misstated facts may result in the rescission of coverage issued in reliance on information given to PEHP, and there will be no benefits payable.

Signature of Retired Employee

Date

Authorization To Deduct Premiums

Please select (1) option below and sign if you would like your premiums to be deducted from your retirement check, otherwise you will be billed monthly for your premium.

☐ Deduct Medical Premiums from Retirement Check

☐ Bill Me for Monthly Premiums

I agree to make payments for benefits by means of deduction from my retirement allowance. Deductions will be made in accordance with the bylaws of Utah Retirement Systems. I hereby request and authorize you to deduct from my allowance the amount necessary to pay for the benefits for which I have been approved.

Signature Of Retired Employee

Date

Please make a copy for your records.

Spouse Information

| | | | |
|---|---|--|-----------------------|
| NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD | | SOCIAL SECURITY NUMBER ____-____-____ | BIRTH DATE (mm/dd/yy) |
| GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed | MEDICARE ID NUMBER ____-____-____ | HOME PHONE |
| HOME ADDRESS | | CITY/STATE/ZIP | EMAIL ADDRESS |

CURRENT MEDICARE COVERAGE

***Note: You must be enrolled in Medicare Parts A and B to enroll in any PEHP Medicare Supplement (medical) plan.**

☐ Part A ☐ Part B Is your coverage provided by a Medicare Advantage Plan? ☐ Yes ☐ No

Company Name / Address _____ Termination Date _____

PLAN SELECTION

You may choose a Medical Plan only, or a Pharmacy Plan only, or a combination of both Medical and Pharmacy.

MEDICAL

PHARMACY

☐ PEHP's Medicare Supplement Medical Plan 100 (Includes Discount Dental Plan)

☐ Basic Pharmacy

☐ PEHP's Medicare Supplement Medical Plan 75 (Includes Discount Dental Plan)

☐ Basic Plus Pharmacy

☐ PEHP's Medicare Supplement Medical Plan 50 (Includes Discount Dental Plan)

☐ Enhanced Pharmacy

☐ No Coverage / Terminate Coverage

I represent that the above information is true and correct. I understand any materially incorrect, or misstated facts may result in the rescission of coverage issued in reliance on information given to PEHP, and there will be no benefits payable.

Signature of Retired Employee

Date

Dependent Information

| | | | |
|---|---|--|-----------------------|
| NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD | | SOCIAL SECURITY NUMBER ____-____-____ | BIRTH DATE (mm/dd/yy) |
| GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed | MEDICARE ID NUMBER ____-____-____ | HOME PHONE |
| HOME ADDRESS | | CITY/STATE/ZIP | |

CURRENT MEDICARE COVERAGE

☐ Part A ☐ Part B ***Note: You must be enrolled in Medicare Parts A and B to enroll in any PEHP Medicare Supplement (medical) plan.**

Is your coverage provided by a Medicare Advantage Plan? ☐ Yes ☐ No

Company Name / Address _____ Termination Date _____

PLAN SELECTION

You may choose a Medical Plan only, or a Pharmacy Plan only, or a combination of both Medical and Pharmacy.

MEDICAL

PHARMACY

☐ PEHP's Medicare Supplement Medical Plan 100 (Includes Discount Dental Plan)

☐ Basic Pharmacy

☐ PEHP's Medicare Supplement Medical Plan 75 (Includes Discount Dental Plan)

☐ Basic Plus Pharmacy

☐ PEHP's Medicare Supplement Medical Plan 50 (Includes Discount Dental Plan)

☐ Enhanced Pharmacy

☐ No Coverage / Terminate Coverage

I represent that the above information is true and correct. I understand any materially incorrect, or misstated facts may result in the rescission of coverage issued in reliance on information given to PEHP, and there will be no benefits payable.

Signature of Retired Employee

Date

SIGNATURES ARE REQUIRED FOR EACH ELIGIBLE APPLICANT FOR THIS FORM TO BE PROCESSED