Considering Medicare? Consider this URS benefit.

PEHP Medicare Supplement is available to anyone who's ever worked for a URS participating employer or married to someone who was. What sets our plans apart?

- Options for every budget. Choose from **three medical plans**, **three prescription drug plans**, **two new dental plans**, and **two new vision plans**.
- Monthly premiums can be deducted from your **URS retirement check**.
- Enroll by mail (form in back of the book) or **by phone** (call 801-366-7555 or 800-765-7347).
- Coverage **out-of-state**.
- Coverage **out-of-country** for urgent and emergency care.
- Medical plans include a **Discount Dental Benefit**, which gives you access to PEHP's dental discounts at no extra charge. Or, choose among **two new dental plans** that pay a portion of your costs (see Page 18).

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PEHP Medicare Supplement Plans

Medicare does not cover some medical and prescription costs. These non-covered costs can be significant. Get additional coverage with PEHP's Medicare Supplement Medical and Medicare Part D-approved Prescription Drug Plans. New this year, dental and vision plans.

- We offer three supplement medical plans, three pharmacy plans, two dental and two vision plans. You may enroll in the plan or plans that meet your individual health care needs.
- All medical plans provide coverage for Medicare Part A and Medicare Part B deductibles, copayments, coinsurance, and Medicare Part B Excess Fees.
- All plans provide medical coverage while you are traveling outside of the United States for urgent and emergency care.
- Medical Plans include discount dental, which gives you access to PEHP's dental discounts when using PEHP in-network providers, saving you as much as 25% (see Page 17).

Enrollment

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 must be enrolled in **either** Medicare Part A **or** Part B.

You can choose a pharmacy plan only, a Medicare Supplemental Medical plan only, or combine a pharmacy plan with the Medicare Supplemental Medical plan.

When you can enroll:

- During open enrollment (Oct. 15 – Dec. 7).
- When you first become eligible for Medicare.
- Within 63 days of losing active group coverage.

How to Enroll

Complete and mail the enrollment form in the back of this book by Dec. 7. Mail to:

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

Or call 801-366-7555 or 800-765-7347 to enroll by phone.

This booklet is for intended to give only a basic overview. For more details, see the PEHP Medicare Supplement Master Policy.

2016 Monthly Rates

Each year, your rates are based on your age at the time of enrollment and will not change until the next plan year.

Medical Plans

Monthly rates per person

Age	<65	65	66	67	68	69	70	71	72	73	74	75+
Plan 100	$158.04	$116.74	$121.34	$125.94	$130.54	$135.14	$139.74	$144.24	$148.84	$153.44	$158.04	$158.04
Plan 75	$121.73	$89.92	$93.46	$97.01	$100.55	$104.09	$107.63	$111.11	$114.65	$118.19	$121.73	$121.73
Plan 50	$89.70	$66.26	$68.87	$71.48	$74.09	$76.70	$79.31	$81.87	$84.48	$87.09	$89.70	$89.70

Pharmacy Plans

Monthly rates per person

Basic	$36.79
Basic Plus	$51.52
Enhanced	$121.91

Vision Plans

Monthly rates per person

EyeMed - Full	$7.53
EyeMed - Eyewear Only	$6.49
Opticare - Full	$8.32
Opticare - Eyewear Only	$6.39

Dental Plans

Monthly rates per person

Dental 1500	$40.56
Dental 1000	$31.81

For More Information

Learn more about Medicare and PEHP Medicare Supplement by attending a free PEHP presentation (see inside cover for the schedule). For additional information about PEHP Medicare Supplement plans, view and download the PEHP Medicare Supplement Master Policy at www.pehp.org/medsup. To get a copy, email publications@pehp.org or call PEHP.

Contact Information

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

www.pehp.org/medsup

Customer Service:
801-366-7555 or 800-765-7347

Billing: 801-366-7574 or 800-765-7347

Medicare Administration
www.medicare.gov
800-633-4227
(TTY/TDD 877-486-2048)

Prescription Benefits (Medicare Part D)
Express Scripts
PO Box 2016
Pine Brook, NJ 07058-2016
www.express-scripts.com
Customer Service: 800-590-2239
(TTY/TDD 800-716-3231)

Social Security Administration
www.ssa.gov
800-772-1213
(TTY/TDD 800-325-0778)

Medical Plan 100

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
Inpatient Hospital Services – Per Benefit Period *Semi-private room and board, miscellaneous expenses*			
First 60 Days	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 *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare Copayment per "lifetime reserve day" for days 91 and beyond	100% of the Medicare Copayment per day for each "lifetime reserve day" and 90% of eligible expenses for days 151 and beyond	Balance
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 100 benefits and Medicare's eligible fees.			
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 *Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital*			
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%

Benefit Period: *Begins the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

Medical Plan 100

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses | *Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.*			
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 *Above Medicare approved amounts*	Nothing	100% of the Medicare Part B excess charges	Nothing
Mental Health Services | *Outpatient treatment (Benefits may vary)*			
Diagnosis *of your condition*	80% of Medicare approved charges, after the Medicare deductible	20% of Medicare approved charges, after the Medicare deductible	Nothing
Services Outside the United States | *For Urgent and Emergent Care only*			
Inpatient Hospital *No day limit. Includes ancillary charges*	Not a covered benefit	100% of billed charges, up to $700 per day; 80% thereafter	Balance
Outpatient Hospital	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 *(Office visits, Diagnostic Lab and X-ray Services, etc.)*	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.		

For additional information, see the PEHP Medicare Supplement Master Policy

Medical Plan 75

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
Inpatient Hospital Services – Per Benefit Period *(see definition on page 4)* *Semi-private room and board, miscellaneous expenses*			
First 60 Days	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 *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare Copayment per "lifetime reserve day" for days 91 and beyond	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◆
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 75 benefits and Medicare's eligible fees.			
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 *Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital*			
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 of $2,470*.*

*Coinsurance for Part B Excess Fees and out of country coverage does not apply

Medical Plan 75

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses | *Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.*			
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 *Above Medicare approved amounts*	Nothing	75% of the Medicare Part B excess charges	25% of the Medicare Part B excess charges
Mental Health Services | *Outpatient treatment (Benefits may vary)*			
Diagnosis *of your condition*	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◆
Services Outside the United States | *For Urgent and Emergent Care only*			
Inpatient Hospital *No day limit. Includes ancillary services*	Not a covered benefit	75% of billed charges, up to $700 per day	Balance
Outpatient Hospital Room Charges *Including ER*	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 *(Office visits, Diagnostic Lab and X-ray Services, etc.)*	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 of $2,470*.*

For additional information, see the PEHP Medicare Supplement Master Policy

*Coinsurance for Part B Excess Fees and out of country coverage does not apply

Medical Plan 50

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
Inpatient Hospital Services – Per Benefit Period *(see definition on page 4)* *Semi-private room and board, miscellaneous expenses*			
First 60 Days	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 *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare Copayment per "lifetime reserve day" for days 91 and beyond	50% of the Medicare Copayment per day for each "lifetime reserve day" and 50% of eligible expenses for days 151 and beyond	50% of the Medicare Copayment per day for each "lifetime reserve day" and 50% of eligible expenses for days 151 and beyond◆
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 50 benefits and Medicare's eligible fees.			
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 *Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital*			
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 of $4,940*.*

*Coinsurance for Part B Excess Fees and out of country coverage does not apply

Medical Plan 50

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses | *Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.*			
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 *Above Medicare approved amounts*	Nothing	50% of the Medicare Part B excess charges	50% of the Medicare Part B excess charges
Mental Health Services | *Outpatient treatment (Benefits may vary)*			
Diagnosis *of your condition*	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◆
Services Outside the United States | *For Urgent and Emergent Care only*			
Inpatient Hospital *No day limit. Includes ancillary serices*	Not a covered benefit	50% of billed charges, up to $700 per day	Balance
Outpatient Hospital Room Charges *Including ER*	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 *(Office visits, Diagnostic Lab and X-ray Services, etc.)*	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 of $4,940*.*

*Coinsurance for Part B Excess Fees and out of country coverage does not apply

For additional information, see the PEHP Medicare Supplement Master Policy

Basic Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: $360 *(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 $3,310.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Mail Order 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	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 Standard Cost-Sharing	10% coinsurance $10 minimum/ no maximum	10% coinsurance $12 minimum/ no maximum	10% coinsurance $12 minimum/ no maximum	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% coinsurance $25 minimum/ no maximum	25% coinsurance $50 minimum/ no maximum	25% coinsurance $75 minimum/ no maximum	25% coinsurance $50 minimum/ $100 maximum
Standard Cost-Sharing	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 Cost-Sharing	50% coinsurance $50 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum	50% coinsurance $150 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum
Standard Cost-Sharing	50% coinsurance $55 minimum/ no maximum	50% coinsurance $105 minimum/ no maximum	50% coinsurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	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: $360 *(combined for both retail and mail)*

Coverage Gap Stage: After your total yearly drug costs reach $3,310, you will pay the following until your yearly out-of-pocket drug costs reach $4,850.				
Brand Drugs	45% 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	58% 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 $4,850, you will pay the greater of 5% coinsurance or the following.				
Retail	**»** a $2.95 copayment for covered generic drugs (including brand drugs treated as generics) **»** a $7.40 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:
	$2.95 minimum/ $75 maximum	$7.40 minimum/ $100 maximum	$7.40 minimum/ no maximum	$2.95 minimum for generics and $7.40 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: $360 *(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 $3,310.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Mail Order 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	$10 copayment	$20 copayment	$30 copayment	$20 copayment
Standard Cost-Sharing	$15 copayment	$25 copayment	$35 copayment	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% coinsurance $25 minimum/ $50 maximum	25% coinsurance $50 minimum/ $100 maximum	25% coinsurance $75 minimum/ $150 maximum	25% coinsurance $50 minimum/ $100 maximum
Standard Cost-Sharing	25% coinsurance $30 minimum/ $50 maximum	25% coinsurance $55 minimum/ $100 maximum	25% coinsurance $80 minimum/ $150 maximum	
Tier 3 Non-Preferred Brand Drugs Preferred Cost-Sharing	50% coinsurance $50 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum	50% coinsurance $150 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum
Standard Cost-Sharing	50% coinsurance $55 minimum/ no maximum	50% coinsurance $105 minimum/ no maximum	50% coinsurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	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: $360 *(combined for both retail and mail)*

Coverage Gap Stage: After your total yearly drug costs reach $3,310, you will pay the following until your yearly out-of-pocket drug costs reach $4,850.				
Brand Drugs	45% 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 58% 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 $4,850, you will pay the greater of 5% coinsurance or the following.				
Retail	» a $2.95 copayment for covered generic drugs (including brand drugs treated as generics) » a $7.40 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:
	$2.95 minimum/ $75 maximum	$7.40 minimum/ $100 maximum	$7.40 minimum/ no maximum	$2.95 minimum for generics and $7.40 minimum for brand drugs, with maximums of: 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: $360 *(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 $3,310.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Mail Order 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	$10 copayment	$20 copayment	$30 copayment	$20 copayment
Standard Cost-Sharing	$15 copayment	$25 copayment	$35 copayment	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% coinsurance $25 minimum/ $50 maximum	25% coinsurance $50 minimum/ $100 maximum	25% coinsurance $75 minimum/ $150 maximum	25% coinsurance $50 minimum/ $100 maximum
Standard Cost-Sharing	25% coinsurance $30 minimum/ $50 maximum	25% coinsurance $55 minimum/ $100 maximum	25% coinsurance $80 minimum/ $150 maximum	
Tier 3 Non-Preferred Brand Drugs Preferred Cost-Sharing	50% coinsurance $50 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum	50% coinsurance $150 minimum/ no maximum	50% coinsurance $100 minimum/ no maximum
Standard Cost-Sharing	50% coinsurance $55 minimum/ no maximum	50% coinsurance $105 minimum/ no maximum	50% coinsurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	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: $360 *(combined for both retail and mail)*

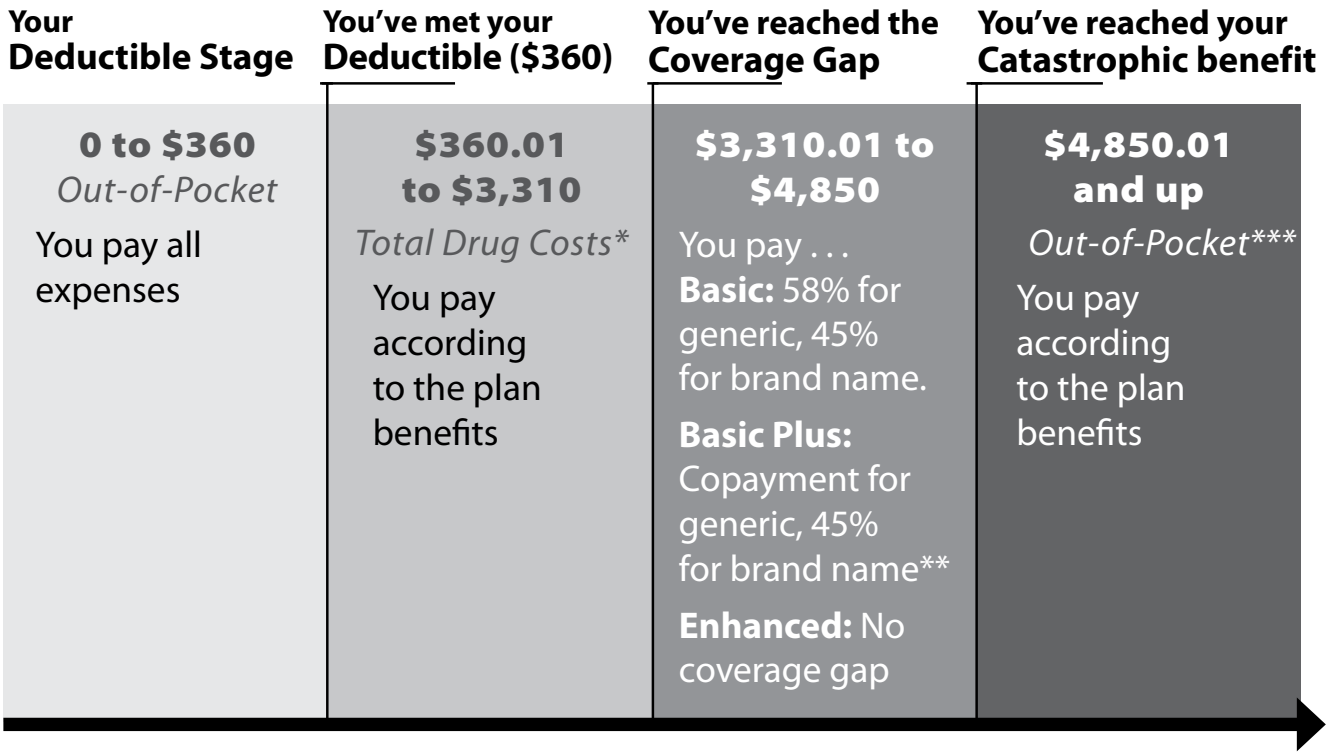
Coverage Gap Stage: After your total yearly drug costs reach $3,310, you will pay no more than the cost-sharing amounts in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $4,850.				
Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,850, you will pay the greater of 5% coinsurance or the following.				
Retail	**»** a $2.95 copayment for covered generic drugs (including brand drugs treated as generics) **»** a $7.40 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:
	$2.95 minimum/ $75 maximum	$7.40 minimum/ $100 maximum	$7.40 minimum/ no maximum	$2.95 minimum for generics and $7.40 minimum for brand drugs, with maximums of: 0-31 days: $150 32-60 days: $300 61-90 days: $450

Understanding the Coverage Gap

One of the more difficult-to-understand concepts of Medicare is the Prescription Drug Plan's "Coverage Gap." Here's a brief explanation.

How the Coverage Gap Works

As your yearly drug spending increases, your benefit changes



***What you've paid, including deductible, and what the plan pays.**

**** Plus a portion of the dispensing fee.**

*****What you've paid, including deductible, co-pays and coinsurances.**

PEHP Discount Dental Benefits

If you enroll in a PEHP Medicare Supplement Medical Plan, you get our Discount Dental benefits at no extra cost.

You'll get discounts on dental services when you see dentists in the PEHP network (find them at www.pehp.org or by calling PEHP). Discount Dental is not applicable while using benefits provided by a group dental plan or a dental plan that offers copays and coinsurances for eligible services.

You'll save an average of 25% on dental services. Costs may vary if a specialist provides the following services. These costs are subject to change. Some examples:

Dental Code	Procedure	Your Cost
1110	Adult Routine Dental Cleaning	$45.25
0120	Periodic adult oral examination	$21.95
0274	Dental bitewings four films	$27.78
2391	Resin based composite one surface posterior filling	$79.30
2392	Resin based composite two surfaces posterior filling	$103.94
2393	Resin based composite three surfaces posterior filling	$129.47
3330	Root canal therapy on a molar (excludes final restoration)	$501.76
2750	Crown – porcelain fused to high noble metal	$572.99
2752	Crown – porcelain fused to noble metal	$546.56
7240	Removal of complete bony impacted tooth	$244.61
2740	Porcelain – ceramic crown build up	$581.06
6010	Surgical placement of implant post	$1,184.06

NOTE: Discount Dental is not applicable while using benefits provided by a group dental plan or a plan that offers copays and coinsurances for eligible services.

PEHP Dental Care

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. Out of network benefits are paid at 20% less than the In-Network Rate.

	Dental 1500	Dental 1000
RATES, DEDUCTIBLES, PLAN MAXIMUMS		
Monthly Premium *Per person*	$40.56	$31.81
Deductible *Does not apply to Diagnostic & Preventive Services*	$0	$50
Annual Benefit Maximum	$1,500	$1,000
DIAGNOSTIC	**You Pay**	**You Pay**
Periodic Oral Examinations	No charge	20% of In-Network Rate
X-rays	20% of In-Network Rate	20% of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	No charge	20% of In-Network Rate
Sealants | *Permanent molars only through age 17*	No charge	20% of In-Network Rate
RESTORATIVE		
Amalgam Restoration	20% of In-Network Rate	20% of In-Network Rate
Composite Restoration	20% of In-Network Rate	20% of In-Network Rate
ENDODONTICS		
Pulpotomy	20% of In-Network Rate	20% of In-Network Rate
Root Canal	20% of In-Network Rate	20% of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	20% of In-Network Rate
ORAL SURGERY		
Extractions	20% of In-Network Rate	20% of In-Network Rate
ANESTHESIA		
General Anesthesia *in conjunction with oral surgery or impacted teeth only*	20% of In-Network Rate	20% of In-Network Rate

Implant and prosthodontic services listed below are not eligible for a period of six months from the date of continuous coverage with PEHP.

PROSTHODONTIC BENEFITS | *Preauthorization may be required*		
Crowns	50% of In-Network Rate	50% of In-Network Rate
Bridges	50% of In-Network Rate	50% of In-Network Rate
Dentures (partial)	50% of In-Network Rate	50% of In-Network Rate
Dentures (full)	50% of In-Network Rate	50% of In-Network Rate
IMPLANTS		
All related services	50% of In-Network Rate	50% of In-Network Rate

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

Opticare Plan: 10-120C/120C

	Exam + Hardware	Hardware Only
Per person	$ 8.32	$ 6.39

Plan Options:

10-120C Full Benefits-*(Eye exam +hardware benefit)**OR **120C Eyewear Only**-*(No eye exam, hardware only benefit)*

LGRP	Select Network	Broad Network	Out-of-network
Eye Exam * (10-120C Plan ONLY)			
Eyeglass exam	$10 Co-pay	$15 Co-pay	♦$40 Allowance
Contact exam	$10 Co-pay	$15 Co-pay	♦$40 Allowance
Dilation	100% Covered	Retail	Included above
Contact Fitting	100% Covered	Retail	Included above
Plastic Lenses (10-120C/120C)			
Single Vision	100% Covered	$10 Co-pay	♦$85 Allowance for lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$10 Co-pay	
Trifocal (FT 7x28)	100% Covered	$10 Co-pay	
Lens Options (10-120C/120C)			
Progressive *(Standard plastic no-line)*	$30 Co-pay	$50 Co-pay	
Premium Progressive Options	20% Discount	No Discount	
Glass lenses	15% Discount	15% Discount	
Polycarbonate	$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount	
Coatings (10-120C/120C)			
Scratch Resistant Coating	100% Covered	$10 Co-pay	
Ultra Violet protection	100% Covered	$10 Co-pay	
Other Options *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	Up to 25% Discount	
Frames (10-120C/120C)			
Allowance Based on Retail Pricing	$120 Allowance	$100 Allowance	♦$80 Allowance
Add'l Eyewear (10-120C/120C)			
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	Up to 25% Off Retail	
Contacts (10-120C/120C)			
Contact benefits is in lieu Of lens and frame benefit.	$120 Allowance	$100 Allowance	♦$80 Allowance
Additional contact purchases:			
***Conventional	Up to 20% off	Retail	
***Disposables	Up to 10% off	Retail	
Frequency (10/120C/120C)			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
LASIK Benefit (10-120C/120C)			
LASIK	$750 Off Per Eye	Not Covered	Not Covered

Discounts

Any item listed as a discount is a merchandise discount only and not an insured benefit. Discounts vary by providers, see provider for details

*** 50% discount varies by provider, ask provider for details.*

**** Must purchase full year supply to receive discounts on select brands. See provider for details.*

***** **LASIK (Refractive surgery) Standard Optical Locations ONLY.** *LASIK services are not an insured benefit – this is a discount only. All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.*

◆ ***Out of Network*** *– Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.*

For more Information please visit www.opticareofutah.com or call 800-363-0950

More, for less…

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the INSIGHT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com or call 1-866-804-0982.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

PEHP Full (Plan H)

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $30
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay, $100 allowance, 20% off balance over $100	Up to $50
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $55
Lenticular	$10 Copay	Up to $55
Standard Progressive Lens	$75	Up to $40
Premium Progressive Lens[Δ]	$95 - $120	
Tier 1	$95	Up to $40
Tier 2	$105	Up to $40
Tier 3	$120	Up to $40
Tier 4	$75, 80% of charge less $120 allowance	Up to $40
Lens Options (paid by the member in addition to the price of the lenses)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay, $120 Allowance, 85% off balance over $120	Up to $96
Disposable	$0 Copay, $120 Allowance, plus off balance over $120	Up to $96
Medically Necessary	$0 Copay, Paid in Full	Up to $200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Exam	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Premiums–monthly		
Per person	$7.53	

[Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

More, for less…

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Hello, Neighbor

- You're on the INSIGHT Network
- For a complete list of providers near you, use our Provider Locator on www.eyemed.com or call 1-866-804-0982.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

PEHP Eyewear Only (Plan F)

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Frames	$0 Copay, $130 allowance, 20% off balance over $130	Up to $65
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $55
Lenticular	$10 Copay	Up to $55
Standard Progressive Lens	$75	Up to $40
Premium Progressive Lens[Δ]	$95 - $120	
Tier 1	$95	Up to $40
Tier 2	$105	Up to $40
Tier 3	$120	Up to $40
Tier 4	$75, 80% of charge less $120 allowance	Up to $40
Lens Options (paid by the member in addition to the price of the lenses)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay, $130 Allowance, 85% off balance over $130	Up to $104
Disposable	$0 Copay, $130 Allowance, plus off balance over $130	Up to $104
Medically Necessary	$0 Copay, Paid in Full	Up to $200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Additional Pairs Discount	Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Premiums–monthly		
Per person	$6.49	

[Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

IMPORTANT NOTICE FROM PEHP ABOUT PEHP's MEDICARE D DRUG PLANS

Please read this notice carefully and keep it where you can find it. This notice has information about PEHP's Medicare drug plans. This information can help you decide whether or not you want to join PEHP's Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about the PEHP prescription drug plans and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEHP has determined the Medicare drug plans offered by PEHP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing prescription drug coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a PEHP Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter during Medicare open enrollment from October 15th to December 7 coverage begins on January 1 for those enrolling during open enrollment.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a PEHP Medicare drug plan, or a Medicare Advantage Plan that includes a drug plan, your current Medicare Drug coverage may be affected in accordance with the Centers for Medicare and Medicaid Services (CMS). **The PEHP Medicare D drug plans provided by PEHP are creditable.**

If you decide to join a PEHP Medicare drug plan and drop your current prescription drug coverage, be aware that you and your eligible dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage.

Contact PEHP's Customer Service Department regarding your current prescription drug coverage at 1-800-765-7347 or 801-366-7575. For more information about this notice please contact your employer's benefit specialist.

NOTE: You'll get this notice each year. You will also get this notice before the next period you can join a Medicare prescription drug plan, and if this prescription drug coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

PEHP
www.pehp.org

Complete and mail to:
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347

Medicare Supplemental Plan
Enrollment and Record Card

Note: Both Social Security Number and Medicare ID Number are required for each applicant.

Reason for enrollment change: _____ Effective date:_____

Retiree Information

Spouse Information on Reverse

YOUR NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD		SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)
GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED	MEDICARE ID NUMBER	HOME PHONE
HOME ADDRESS	CITY/STATE/ZIP	EMAIL ADDRESS	
PREVIOUS PUBLIC EMPLOYER			

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 other non-PEHP medical coverage? ☐ YES ☐ NO

If yes, provide company name: _____ Termination Date: _____

PLAN SELECTION

MEDICAL (all medical plans include discount dental plan)

- ☐ PEHP Medicare Supplement Medical Plan 100
- ☐ PEHP Medicare Supplement Medical Plan 75
- ☐ PEHP Medicare Supplement Medical Plan 50
- ☐ No Coverage / Terminate Coverage

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

PHARMACY

- ☐ Basic Pharmacy
- ☐ Basic Plus Pharmacy
- ☐ Enhanced Pharmacy
- ☐ No Coverage / Terminate Coverage

DENTAL

- ☐ Dental 1500 – $1,500 Annual Benefit Maximum
- ☐ Dental 1000 – $1,000 Annual Benefit Maximum
- ☐ No Coverage / Terminate Coverage

VISION

- ☐ Opticare - Full
- ☐ Opticare - Eyewear only
- ☐ EyeMed - Full (Plan H)
- ☐ EyeMed - Eyewear only (Plan F)
- ☐ 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

☐ HRA Withdrawal, ACH Deduction, or Bill Me Monthly

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

YOUR NAME (last, first, middle initial) AS IT APPEARS ON YOUR MEDICARE ID CARD		SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)
GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED	MEDICARE ID NUMBER	HOME PHONE
HOME ADDRESS	CITY/STATE/ZIP	EMAIL ADDRESS	
PREVIOUS PUBLIC EMPLOYER			

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 other non-PEHP medical coverage? ☐ YES ☐ NO

If yes, provide company name: _____ Termination Date: _____

PLAN SELECTION

MEDICAL (all medical plans include discount dental plan)

- ☐ PEHP Medicare Supplement Medical Plan 100
- ☐ PEHP Medicare Supplement Medical Plan 75
- ☐ PEHP Medicare Supplement Medical Plan 50
- ☐ No Coverage / Terminate Coverage

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

PHARMACY

- ☐ Basic Pharmacy
- ☐ Basic Plus Pharmacy
- ☐ Enhanced Pharmacy
- ☐ No Coverage / Terminate Coverage

DENTAL

- ☐ Dental 1500 – $1,500 Annual Benefit Maximum
- ☐ Dental 1000 – $1,000 Annual Benefit Maximum
- ☐ No Coverage / Terminate Coverage

VISION

- ☐ Opticare - Full
- ☐ Opticare - Eyewear only
- ☐ EyeMed - Full (Plan H)
- ☐ EyeMed - Eyewear only (Plan F)
- ☐ 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.