2020

Medicare Supplement

Enrollment Guide

Enrollment information, plan changes,
and a brief overview of drug plans

» Open enrollment runs October 15 through December 7

» Enroll or make changes online (see Page 27)

» Attend a meeting to learn more *(schedule on inside cover)*

» Not changing plans? You will be automatically re-enrolled

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

Attend a free presentation

URS Utah Retirement Systems

Join us for a presentation to learn about Medicare and PEHP's Medicare Supplement plans. We'll be available after each presentation to answer questions.

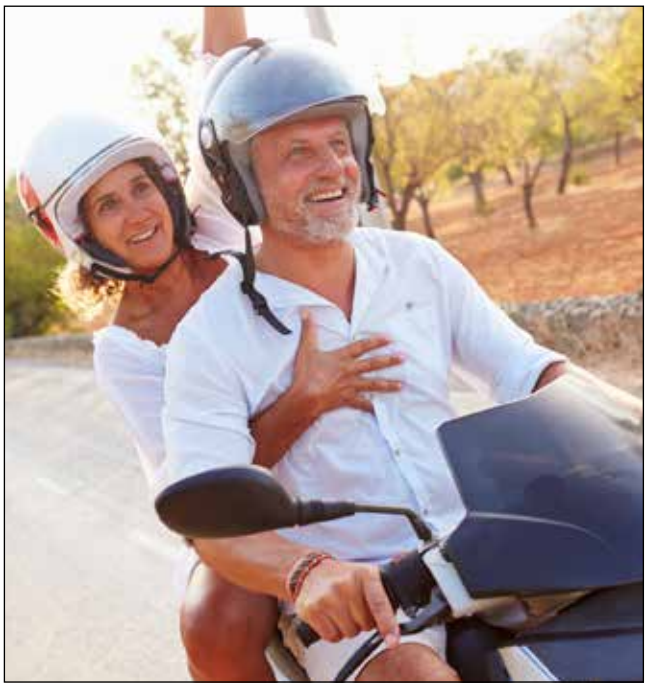
Fall 2019 Schedule

To see an updated schedule, visit www.pehp.org/medsup

County	Date & Time	Location
Box Elder County	**Oct. 17, 2019:** 10 a.m. & 1 p.m.	Box Elder County Council Chambers 1 South Main Street, Brigham City
Cache County	**Nov. 19, 2019:** 10 a.m. & 1 p.m.	North Logan City Library 475 E. 2500 N., Logan
Carbon County	**Nov. 12, 2019:** 1 p.m.	Price City Council Chambers 185 East Main Street, Price
Davis County	**Oct. 31, 2019:** 10 a.m. & 3 p.m. **Nov. 6, 2019:** 10 a.m. & 3 p.m. *Park on north side of building.*	Davis County Administrative Offices 61 South Main Street, Farmington Room 131A (North Entrance)
Duchesne County	**Oct. 16, 2019:** 1 p.m.	Uintah Basin Technical College, Rm T17 1100 E Lagoon St, Roosevelt
Salt Lake County	**Oct. 24, 2019:** 10 a.m. **Oct. 30, 2019:** 9:30 a.m. & 2:30 p.m.	Salt Lake County Council Chambers 2001 S State Street, N-460, Salt Lake City
	Oct. 22, 2019: 10 a.m., 1 p.m. & 3 p.m. **Nov. 14, 2019:** 10 a.m., 1 p.m. & 3 p.m.	Murray City Council Chambers 5025 S. State Street, Murray
	Nov. 13, 2019: 10 a.m. & 1 p.m. *Park on south side of building.*	Draper City Council Chambers 1020 E. Pioneer Road, Draper
Uintah County	**Oct. 16, 2019:** 11 a.m.	Uintah Basin Technical College, Rm CB145 450 N 2000 W, Vernal
Utah County	**Oct. 23, 2019:** 10 a.m. & 1 p.m.	Mapleton City Council Chambers 125 West 400 North, Mapleton
Wasatch County	**Nov. 7, 2019:** 10 a.m., 1 p.m. & 3 p.m.	Community Services Building 55 South 500 East, Heber Conference Room B
Washington County	**Nov. 7, 2019:** 10 a.m. & 1 p.m.	Dixie State University Taylor Health Science Bldg, Room 156 1526 S Medical Center Dr., St. George
Weber County	**Oct. 29, 2019:** 10 a.m., 1 p.m. & 3 p.m.	Dept of Human Resources 950 East 25th Street, Ogden Conference Room

Did You Know?

- Monthly premiums can be deducted from your **URS retirement check**. See page 3.
- Benefits include **out-of-state** coverage for medical plans.
- Medical plans include **out-of-country** coverage on medical plans (for urgent and emergent care only).
- Need **dental** or **vision services**? See pages 20-25 to find the right coverage.
- Check out PEHP's **discounts** on healthy lifestyle products and services (www.pehp.org/plus).



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Contact Information

PEHP
560 East 200 South
Salt Lake City, UT 84102-2004
www.pehp.org

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

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

Prescription Benefits (Medicare Part D)
Express Scripts
www.express-scripts.com
Customer Service: 800-590-2239
(TTY/TDD 800-716-3231)

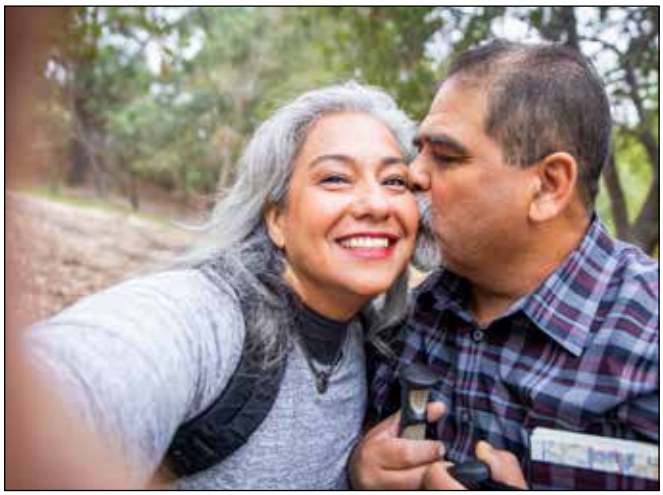
Social Security Administration
www.ssa.gov
800-772-1213
(TTY/TDD 800-325-0778)

PEHP Medicare Supplement Plans

OPEN ENROLLMENT: OCTOBER 15 – DECEMBER 7

Take the time to review your coverage. **Not enough?** Choose a more generous medical plan or add dental and vision. **Too much?** Change to a lower-costing plan with less coverage. **Just right?** Do nothing and you'll continue to be enrolled in the same benefits!

- Three supplement plans that cover 100%, 75%, or 50% after what Medicare pays.
- All medical plans provide coverage options nationwide or outside the U.S.
- Three pharmacy plans to help cover your prescriptions.
- Two dental plans with a $1,000 or $1,500 annual benefit.
- Four vision plans, covering eyewear and/or exams at various retailers.



How to Enroll & Make Changes

If you don't want to make changes, you don't need to do anything.

To make changes to your existing plans, you must do so by December 7.

By Mail:
Complete the enclosed enrollment form (on Page 35) and send it to:

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

Online:
Visit **www.pehp.org** and complete the online enrollment instructions (on Page 26).

For More Information

For additional information about PEHP Medicare Supplement plans, view and download the PEHP Medicare Supplement Master Policy at **www.pehp.org/medsup**. To receive a copy, email **publications@pehp.org** or call PEHP.

2020 Monthly Rates

Rates are set for one year based on your age at enrollment. If you're under age 65, your rates will adjust at age 65.

Medical Plans

Monthly rates per person

Age	<65	65	66	67	68	69	70	71	72	73	74
Plan 100	$203.75	$123.41	$127.42	$131.44	$135.45	$139.47	$143.49	$147.50	$151.52	$155.54	$159.56
Plan 75	$156.97	$95.05	$98.14	$101.24	$104.33	$107.43	$110.53	$113.62	$116.72	$119.82	$122.91
Plan 50	$115.67	$70.03	$72.32	$74.60	$76.88	$79.16	$81.44	$83.72	$86.01	$88.29	$90.57

Monthly rates per person

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan 100	$163.57	$167.59	$171.61	$175.62	$179.64	$183.65	$187.68	$191.69	$195.71	$199.72	$203.75
Plan 75	$126.01	$129.11	$132.19	$135.29	$138.39	$141.48	$144.58	$147.68	$150.77	$153.87	$156.97
Plan 50	$92.85	$95.13	$97.42	$99.69	$101.98	$104.26	$106.54	$108.83	$111.10	$113.39	$115.67

Pharmacy Plans

Monthly rates per person

Basic	$44.00
Basic Plus	$66.10
Enhanced	$178.00

Vision Plans

Monthly rates per person

EyeMed - Full	$7.39
EyeMed - Eyewear Only	$6.38
Opticare - Full	$8.32
Opticare - Eyewear Only	$6.39

Dental Plans

Monthly rates per person

Dental 1500	$43.48
Dental 1000	$27.88

4 Ways to Pay Your Premium

Select the method of payment under the Authorization to Deduct Premiums section of the PEHP Medicare enrollment form in the back of this book.

1. Deduct premiums from your URS retirement check.
2. Receive a monthly bill and send payment to PEHP.
3. Deduct from your PEHP Health Reimbursement Account (HRA).
4. Automatic bank withdrawal.

Medical Plan 100

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
Inpatient Hospital Services – Per Benefit Period *(see definition below)* *Semi-private room and board, miscellaneous expenses*			
Deductible *Per Benefit Period*	Not a covered benefit	100% of the Medicare deductible	Nothing
First 60 Days	All approved charges after the Medicare deductible	Nothing	Nothing
Days 61 to 90	All approved charges, except for the Medicare co-pay	100% of the Medicare co-pay	Nothing
91 Days & Beyond *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare co-pay per "lifetime reserve day"	100% of the Medicare co-pay per "lifetime reserve day"	Nothing
Additional 365 Days *Once lifetime reserve days are used** *Preauthorization required*	Nothing	90% of the Medicare eligible expenses	Balance
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period and will cover an additional 60 lifetime reserve days. This PEHP inpatient hospital benefit will provide you with an additional 365 days that can be used over the course of your lifetime.			

Benefit Period: *Begins the day you are admitted as an inpatient in a hospital or skilled nursing facility (SNF). 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.*

Medicare Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

**When Medicare Part A hospital benefits are exhausted, PEHP will pay a percentage of the amount Medicare would have paid for up to 365 billed inpatient days. During this time the hospital is prohibited from billing you for the balance between its billed charges and the amount Medicare would have paid. You will be responsible for the percentage portion PEHP did not pay.*

Medical Plan 100 continued

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
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 co-pay per day	100% of the Medicare co-pay per day	Nothing
Day 101 & Beyond	No benefits are payable	No benefits are payable	100%

Medical Plan 100 continued

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 *Per calendar year*	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, $50,000 per lifetime*			
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 (Ground or Air) *For medical emergencies only, as determined by PEHP*	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*			
Deductible *Per Benefit Period*	Not a covered benefit	75% of the Medicare deductible	25% of the Medicare deductible◆
First 60 Days	All approved charges after the Medicare deductible	Nothing	Nothing
Days 61 to 90	All approved charges, except for the Medicare co-pay	75% of the Medicare co-pay	25% of the Medicare co-pay◆
91 Days & Beyond *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare co-pay per "lifetime reserve day"	75% of the Medicare co-pay per "lifetime reserve day"	25% of the Medicare co-pay per "lifetime reserve day" ◆
Additional 365 Days *Once lifetime reserve days are used* Preauthorization required*	Nothing	75% of the Medicare eligible expenses	25% of the Medicare eligible expenses
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period and will cover an additional 60 lifetime reserve days. This PEHP inpatient hospital benefit will provide you with an additional 365 days that can be used over the course of your lifetime.			

◆*Applies to the annual out-of-pocket maximum limit of $2,780. Once the maximum out of pocket is met, PEHP pays 100% of Medicare eligible services based on Medicare's eligible fee schedule. Co-insurance for Part B excess fees and out-of-country coverage does not apply.*

Medicare Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

**When Medicare Part A hospital benefits are exhausted, PEHP will pay a percentage of the amount Medicare would have paid for up to 365 lifetime inpatient days. During this time the hospital is prohibited from billing you for the balance between its billed charges and the amount Medicare would have paid. You will be responsible for the percentage portion PEHP did not pay.*

Medical Plan 75 continued

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
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 co-pay per day	75% of the Medicare co-pay per day	25% of the Medicare co-pay per day◆
Day 101 & Beyond	No benefits are payable	No benefits are payable	100%

◆*Applies to the annual out-of-pocket maximum limit of $2,780. Co-insurance for Part B excess fees and out-of-country coverage does not apply. For additional information, see the PEHP Medicare Supplement Master Policy.*

Medical Plan 75 continued

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, $50,000 per lifetime*			
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 (Ground or Air) *For medical emergencies only, as determined by PEHP*	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 $2,780. Co-insurance for Part B excess fees and out-of-country coverage does not apply. For additional information, see the PEHP Medicare Supplement Master Policy.*

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*			
Deductible	Not a covered benefit	50% of the Medicare deductible	50% of deductible◆
First 60 Days	All approved charges after the Medicare deductible	Nothing	Nothing
Days 61 to 90	All approved charges, except for the Medicare co-pay	50% of the Medicare co-pay	50% of the Medicare co-pay◆
91 Days & Beyond *While using your 60 lifetime reserve days*	All approved charges, except for the Medicare co-pay per "lifetime reserve day"	50% of the Medicare co-pay per "lifetime reserve day"	50% of the Medicare co-pay per "lifetime reserve day" ◆
Additional 365 Days *Once lifetime reserve days are used** *Preauthorization required*	Nothing	50% of the Medicare eligible expenses	50% of the Medicare eligible expenses
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period and will cover an additional 60 lifetime reserve days. This PEHP inpatient hospital benefit will provide you with an additional 365 days that can be used over the course of your lifetime.			

◆ *Applies to the annual out-of-pocket maximum limit of $5,560. Once the maximum out of pocket is met, PEHP pays 100% of Medicare eligible services based on Medicare's eligible fee schedule. Co-insurance for Part B excess fees and out-of-country coverage does not apply.*

Medicare Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

**When Medicare Part A hospital benefits are exhausted, PEHP will pay a percentage of the amount Medicare would have paid for up to 365 lifetime inpatient days. During this time the hospital is prohibited from billing you for the balance between its billed charges and the amount Medicare would have paid. You will be responsible for the percentage portion PEHP did not pay.*

Medical Plan 50 continued

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
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 co-pay per day	50% of the Medicare co-pay per day	50% of the Medicare co-pay per day◆
Day 101 & Beyond	No benefits are payable	No benefits are payable	100%

◆*Applies to the annual out-of-pocket maximum limit of $5,560. Co-insurance for Part B excess fees and out-of-country coverage does not apply. For additional information, see the PEHP Medicare Supplement Master Policy.*

Medical Plan 50 continued

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, $50,000 per lifetime*			
Inpatient Hospital *No day limit. Includes ancillary services*	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 (Ground or Air) *For medical emergencies only, as determined by PEHP*	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 $5,560. Co-insurance 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 co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

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) reaches $4,020.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Home Delivery 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	10% co-insurance $5 minimum/ no maximum	10% co-insurance $7 minimum/ no maximum	10% co-insurance $7 minimum/ no maximum	10% co-insurance $5 minimum/ $75 maximum
Standard Cost-Sharing	10% co-insurance $10 minimum/ no maximum	10% co-insurance $12 minimum/ no maximum	10% co-insurance $12 minimum/ no maximum	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% co-insurance $25 minimum/ no maximum	25% co-insurance $50 minimum/ no maximum	25% co-insurance $75 minimum/ no maximum	25% co-insurance $50 minimum/ $100 maximum
Standard Cost-Sharing	25% co-insurance $30 minimum/ no maximum	25% co-insurance $55 minimum/ no maximum	25% co-insurance $80 minimum/ no maximum	
Tier 3 Non-Preferred Brand Drugs Preferred Cost-Sharing	50% co-insurance $50 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum	50% co-insurance $150 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum
Standard Cost-Sharing	50% co-insurance $55 minimum/ no maximum	50% co-insurance $105 minimum/ no maximum	50% co-insurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ maximums: 0-31 days: $150 32-60 days: $300 61-90 days: $375

**Tier 3 contains both generic and brand drugs.*

Basic Drug Plan continued

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $4,020, you will pay the following until your yearly out-of-pocket drug costs reach $6,350.				
Brand Drugs	25% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 70% discount and the plan pays the difference.)			
Generic Drugs	25% 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 $6,350, you will pay the greater of 5% co-insurance or the following.				
Retail	» a $3.60 co-pay for covered generic drugs (including brand drugs treated as generics) » a $8.95 co-pay for all other covered drugs.			
Home Delivery	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	$3.60 minimum/ $75 maximum	$8.95 minimum/ $100 maximum	$8.95 minimum/ no maximum	$3.60 minimum for generics and $8.95 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 co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

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) reaches $4,020.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Home Delivery 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	$10 co-pay	$20 co-pay	$30 co-pay	$20 co-pay
Standard Cost-Sharing	$15 co-pay	$25 co-pay	$35 co-pay	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% co-insurance $25 minimum/ $50 maximum	25% co-insurance $50 minimum/ $100 maximum	25% co-insurance $75 minimum/ $150 maximum	25% co-insurance $50 minimum/ $100 maximum
Standard Cost-Sharing	25% co-insurance $30 minimum/ $50 maximum	25% co-insurance $55 minimum/ $100 maximum	25% co-insurance $80 minimum/ $150 maximum	
Tier 3 Non-Preferred Brand Drugs Preferred Cost-Sharing	50% co-insurance $50 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum	50% co-insurance $150 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum
Standard Cost-Sharing	50% co-insurance $55 minimum/ no maximum	50% co-insurance $105 minimum/ no maximum	50% co-insurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ maximums: 0-31 days: $150 32-60 days: $300 61-90 days: $450

**Tier 3 contains both generic and brand drugs*

Basic Plus Drug Plan continued

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $4,020, you will pay the following until your yearly out-of-pocket drug costs reach $6,350.				
Brand Drugs	25% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 70% discount and the plan pays the difference.)			
Generic Drugs	Tier 1 generic drugs are paid at the same co-pay as in the Initial Coverage Stage. All other covered generic drugs (not on Tier 1) you pay 25% of the plan's costs.			
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 $6,350, you will pay the greater of 5% co-insurance or the following.				
Retail	» a $3.60 co-pay for covered generic drugs (including brand drugs treated as generics) » a $8.95 co-pay for all other covered drugs.			
Home Delivery	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	$3.60 minimum/ $75 maximum	$8.95 minimum/ $100 maximum	$8.95 minimum/ no maximum	$3.60 minimum for generics and $8.95 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 co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

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) reaches $4,020.

Tier	Retail 31-day Supply	Retail 60-day Supply	Retail 90-day Supply	Home Delivery 90-day Supply
Tier 1 Generic Drugs Preferred Cost-Sharing	$10 co-pay	$20 co-pay	$30 co-pay	$20 co-pay
Standard Cost-Sharing	$15 co-pay	$25 co-pay	$35 co-pay	
Tier 2 Preferred Brand Drugs Preferred Cost-Sharing	25% co-insurance $25 minimum/ $50 maximum	25% co-insurance $50 minimum/ $100 maximum	25% co-insurance $75 minimum/ $150 maximum	25% co-insurance $50 minimum/ $100 maximum
Standard Cost-Sharing	25% co-insurance $30 minimum/ $50 maximum	25% co-insurance $55 minimum/ $100 maximum	25% co-insurance $80 minimum/ $150 maximum	
Tier 3 Non-Preferred Brand Drugs Preferred Cost-Sharing	50% co-insurance $50 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum	50% co-insurance $150 minimum/ no maximum	50% co-insurance $100 minimum/ no maximum
Standard Cost-Sharing	50% co-insurance $55 minimum/ no maximum	50% co-insurance $105 minimum/ no maximum	50% co-insurance $155 minimum/ no maximum	
Tier 4 Specialty Drugs *Preferred and Standard Cost-Sharing*	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ no maximum	25% co-insurance no minimum/ maximums: 0-31 days: $150 32-60 days: $300 61-90 days: $450

**Tier 3 contains both generic and brand drugs*

Enhanced Drug Plan continued

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $435 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $4,020, you will pay no more than the cost-sharing amounts in the initial coverage stage until your yearly out-of-pocket drug costs reach $6,350.				
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 $6,350, you will pay the greater of 5% co-insurance or the following.				
Retail	» a $3.60 co-pay for covered generic drugs (including brand drugs treated as generics) » a $8.95 co-pay for all other covered drugs.			
Home Delivery	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	$3.60 minimum/ $75 maximum	$8.95 minimum/ $100 maximum	$8.95 minimum/ no maximum	$3.60 minimum for generics and $8.95 minimum for brand drugs, with maximums of: 0-31 days: $150 32-60 days: $300 61-90 days: $450

Understanding the Coverage Gap

Most will not reach the Coverage Gap. When the total cost of your Part D drugs reaches $4,020, you move on to the Coverage Gap stage. The $4,020 includes the amount you have paid toward your deductible, your co-pays and the amount PEHP has paid.

How the Coverage Gap Works

As your yearly drug spending increases, your benefit changes

Your **Deductible Stage**	You've met your **Deductible ($435)**	You've reached the **Coverage Gap**	You've reached your **Catastrophic benefit**
$0 to $435	**$435.01 to $4,020** *Total Drug Costs**	**$4,020.01 to $6,350**	**$6,350.01 and up** *Out-of-Pocket****
You pay all expenses	You pay according to your plan benefits	You pay . . . **Basic:** 25% for generic, 25% for brand name** **Basic Plus:** Co-pay for Tier 1 generic, 25% for other covered generic, 25% for brand name** **Enhanced:** No coverage gap	You pay according to the plan benefits

*** Total Drug Costs = 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 co-insurances.**

PEHP Dental Plans at a Glance

To enroll in a PEHP Dental Plan, use the enrollment form in the back of this book or enroll online at www.pehp.org (existing members only, see Page 26).

DENTAL PLAN	Dental 1500	Dental 1000
Monthly Premium	$43.48	$27.88
Deductible	$0	$50
Annual Benefit Maximum	$1,500	$1,000
Benefits		
Preventive/ Cleaning	Covered at 100%	You pay 20% of in-network rate
Root Canal *For a molar*	You pay 20% of in-network rate	You pay 20% of in-network rate after deductible
Crown *Porcelain fused to high noble metal*	You pay 50% of in-network rate	You pay 50% of in-network rate after deductible
Dental Network	Visit **www.pehp.org/providerlookup** for a complete list.	

PEHP Discount Dental Benefit

If you enroll in a PEHP Medicare Supplement Medical Plan, you receive our discount dental benefit* at no extra cost.

You're eligible for savings of 25% on dental services when you visit dentists in the PEHP network (find them at www.pehp.org or by calling PEHP).

If you want dental coverage during retirement, consider enrolling in a PEHP Dental Plan. See pages 21 and 22 for details.

PEHP Dental 1500 Plan

If you use an out- of-network provider, your benefits will be reduced by 20%. Out-of-network providers may collect charges that exceed PEHP's in-network rate. To view a list of dentists in the PEHP network visit www. pehp.org or call PEHP.

	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Monthly Premium Per person	**$43.48**	
Deductible Does not apply to diagnostic or preventive services	None	None
Annual Benefit Max	**$1,500**	**$1,500**
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	No Charge	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** 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	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	**20%** of In-Network Rate	**40%** of In-Network Rate

Implant and prosthodontic services below are not eligible for six months from the date of continuous coverage with a PEHP-sponsored dental plan.

PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All related services	**50%** of In-Network Rate	**70%** 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 a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

PEHP Dental 1000 Plan

If you use an out-of-network provider, your benefits will be reduced by 20%. Out-of-network providers may collect charges that exceed PEHP's in-network rate. To view a list of dentists in the PEHP network visit www. pehp.org or call PEHP.

	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Monthly Premium Per person	**$27.88**	
Deductible Does not apply to diagnostic or preventive services	**$50**	**$50**
Annual Benefit Max	**$1,000**	**$1,000**
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**20%** of In-Network Rate	**40%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate
RESTORATIVE		
Amalgam Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS		
Pulpotomy	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS		
	20% of In-Network Rate	**40%** of In-Network Rate
ORAL SURGERY		
Extractions	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	**20%** of In-Network Rate	**40%** of In-Network Rate

Implant and prosthodontic services below are not eligible for six months from the date of continuous coverage with a PEHP-sponsored dental plan.

PROSTHODONTIC BENEFITS | Preauthorization may be required		
Crowns	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS		
All related services	**50%** of In-Network Rate	**70%** 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 a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

Opticare Plans: 10-175/150C 175/150C

	Monthly	Exam + Eyewear	Eyewear Only
	Per person	$ 8.32	$ 6.39

Plan Options:

10-175/150C *Full* Benefits-*(Eye Exam +Eyewear Benefit)* **175/150 Eyewear Only**-*(NO Eye Exam)*

LGRP	**Select Network**	**Broad Network**	**Out-of-network**
Eye Exam (10-175/150C Full Benefit)			
Eyeglass exam	$10 Co-pay	$10 Co-pay	♦$40 Allowance
Contact exam	$10 Co-pay	$10 Co-pay	♦$40 Allowance
Dilation	100% Covered	100% Covered	Included above
Contact Fitting	100% Covered	Retail	Included above
Retinal Imaging	$20 Co-pay	$39 Co-pay	
Plastic Lenses			
Single Vision	100% Covered	$10 Co-pay	♦$70 Allowance
Bifocal (FT 28)	100% Covered	$10 Co-pay	for lenses, options,
Trifocal (FT 7x28)	100% Covered	$10 Co-pay	and coatings
Lens Options			
Progressive *(Standard plastic no-line)*	$30 Co-pay	$50 Co-pay	
Premium Progressive Options	$80 Co-pay	$100 Co-pay	
Ultra Premium Progressive Options	Up to 20% Discount	Up to 20% Discount	
Polycarbonate	$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount	
Coatings			
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			
Allowance Based on Retail Pricing	$175 Allowance	$140 Allowance	♦$70 Allowance
Additional Eyewear			
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	Up to 25% Off Retail	
Contacts			
Contact benefits is in lieu Of lens and frame benefit.	$150 Allowance	$120 Allowance	♦$100 Allowance
Additional contact purchases:			
***Conventional	Up to 20% off	Retail	
***Disposables	Up to 10% off	Retail	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
LASIK Benefit			
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

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

PEHP Full (Plan H)

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $30
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay, $100 Allowance, 80% of charge over $100	Up to $50
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $25
Bifocal	$10 Co-pay	Up to $40
Trifocal	$10 Co-pay	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
Lenticular	$10 Co-pay	Up to $55
Lens Options		
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	N/A
Other Add-Ons and Services	20% off retail	N/A
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
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay, $120 Allowance, 85% of charge over $120	Up to $96
Disposable	$0 Co-pay, $120 Allowance; plus balance over $120	Up to $96
Medically Necessary	$0 Co-pay, 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	
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Premiums–monthly Per person	$7.39

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. [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. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

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Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

PEHP Eyewear Only (Plan F)

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Frames	$0 Copay, $130 allowance, 80% of charge 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% of charge 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	
Additional Discounts (Additional discounts are not insured benefits)		
Complete pair of prescription eyeglasses	40% off	
Non-prescription sunglasses	20% off	
Remaining balance beyond plan coverage	20% off	

Premium- Monthly Per person	$6.38

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. [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. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

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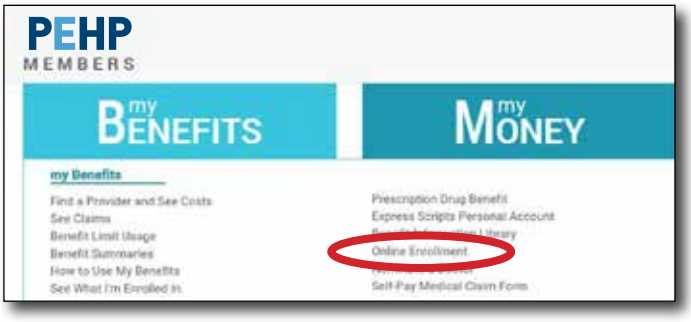
Online Enrollment for Current Members

Online enrollment is available for current PEHP Medicare Supplement members from Oct. 15-Dec. 7. You can make any changes online during this period, or you can fill out paper enrollment forms to make changes. Forms are located in the back of this book.

If you are not making changes, no action is necessary. Your current coverage will remain in effect for 2019.

STEP 1: Log into your personal online account or create one at www.pehp.org. You will need your Subscriber ID number on your current PEHP ID card.

STEP 2: Once you log in, you will be directed to the PEHP Members page. During the open enrollment period, you will have access to an online enrollment link, under the MyBenefits menu.



STEP 3: After clicking on the link you will come to the Medicare Supplement landing page. You can make changes to your existing plans, as well as add/change spouse or dependent coverage.

STEP 4: Click on the "Enroll/Change" button to make plan changes to either your medical or pharmacy coverage. If you're not making changes, make sure the coverage you have is accurate.

STEP 5: When you're finished with updates, review your information. After you've read the terms and conditions, signify you agree by typing your name exactly as shown. You must use all capital letters and punctuation if displayed.

STEP 6: You'll receive an enrollment confirmation. Click "Print" for a print-formatted PDF. This confirmation is for your personal records. You can return to the Online Enrollment page to make additional changes.

For assistance with online enrollment, call 801-366-7410 or 800-753-7410

New Members

Please submit a paper enrollment form (located in the back of this book) and mail to:

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

PEHPplus

Adding to Your Health

PEHP members enjoy exclusive offers on healthy lifestyle products and services through PEHPplus.

Visit **www.pehp.org/plus** to see a complete list of savings, such as:

VASA FITNESS MEMBERSHIPS

» Includes access to all locations and all classes, including Silver Sneakers classes onsite.

AND MORE

PEHPplus also offers discounts on other services including eyewear, lasik, massages, spas, fitness classes, and more.

www.pehp.org/plus

HealthCoaching

Free Health Coaching Available to PEHP Medicare Supplement Members

If you have a body mass index (BMI) of 30 or higher, you qualify for PEHP Health Coaching. Whether you want to lose weight, learn to eat healthier or get more active, we can provide encouragement and resources to help you along the way. You will work with a qualified personal health coach in a confidential partnership for 6-12 months to help achieve your health goals.

Learn more:
www.pehp.org/members/pehp-health-coaching

Call 801-366-7300 or 855-366-7300, email healthcoaching@pehp.org.

IMPORTANT NOTICE FROM PEHP ABOUT
PEHP's 2020 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 enroll in PEHP's Medicare drug plan. If you are considering enrolling, 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 enroll in a Medicare Prescription Drug Plan or enroll in 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 2020 Medicare drug plans offered by PEHP are, 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 enroll in a PEHP Medicare drug plan.

When Can You Enroll in a Medicare Drug Plan?

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year thereafter during Medicare open enrollment from October 15 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 enroll in a Medicare drug plan.

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

If you decide to enroll in 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 2020 PEHP Medicare D drug plans provided by PEHP are creditable**. If you decide to enroll in 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 Enroll in a Medicare Drug Plan?

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

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 800-765-7347 or 801-366-7555. 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 enroll in 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 or, 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 800-MEDICARE (800-633-4227). TTY users should call 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 800- 772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you enroll 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).

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.

PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
www.pehp.org

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 NUMBER (AS IT APPEARS ON YOUR ID CARD)	
HOME ADDRESS / CITY/STATE/ZIP	PRIMARY PHONE	ALTERNATE PHONE
MAILING ADDRESS (*if different from Home Address*)		
PREVIOUS PUBLIC EMPLOYER	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.

Will you have Medicare A and B when this plan takes effect? ☐ YES ☐ NO

Do you currently have other non-PEHP medical coverage other than Medicare? ☐ 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 and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below, I hereby: (1) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (2) agree to the terms and conditions in the PEHP Master Policy.

_____ _____

SIGNATURE OF RETIRED EMPLOYEE DATE

Authorization To Deduct Premiums

Please select one option below and sign.

- ☐ Please **deduct** my portion of costs **from my URS pension retirement check**. (New retirees may be billed up to three months prior to pension deduction).
- ☐ Please **deduct** from my HRA monthly for my portion of costs. *Authorization form required.*
- ☐ Please **bill me** (paper bill or ACH withdrawal) monthly for my portion of costs. *Authorization form required.*

I agree to make payments for benefits by means authorized above. Pension check 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 **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 NUMBER (AS IT APPEARS ON YOUR ID CARD)

HOME ADDRESS CITY/STATE/ZIP	PRIMARY PHONE	ALTERNATE PHONE

MAILING ADDRESS (*if different from Home Address*)

PREVIOUS PUBLIC EMPLOYER	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.

Will you have Medicare A and B when this plan takes effect? ☐ YES ☐ NO

Do you currently have other non-PEHP medical coverage other than Medicare? ☐ 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 and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below, I hereby: (1) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (2) agree to the terms and conditions in the PEHP Master Policy.

_____ _____

SIGNATURE OF RETIRED EMPLOYEE DATE

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

PEHP
Health & Benefits

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

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See inside for important benefit changes

PEHP Medicare Supplement » Attend a free presentation to learn more (schedule on inside front cover)