Medicare Supplement

Enrollment Guide 2024

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 4)

» Join us at a free meeting to learn more

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

PEHP Health & Benefits

PROUDLY SERVING UTAH PUBLIC EMPLOYEES

Did You Know?

- Medical plans include **out-of-country** coverage on medical plans (for urgent and emergency care only).
- Benefits include **out-of-state** coverage for medical plans.
- Need **dental** or **vision services**? See pages 25-31 to find the right coverage.
- Check out PEHPplus **discounts** on healthy lifestyle products and services (www.pehp.org/pehpplus).

Contents

Contact Information

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

Retiree Health Insurance Counselors: 801-366-7499

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

Billing: 800-765-7347

Pharmacy Dept: 801-366-7551 or 888-366-7551

Hours: Monday-Friday, 8 am-5 pm

Medicare Administration
www.medicare.gov
800-633-4227

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

Social Security Administration
www.ssa.gov
800-772-1213

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 medical supplement plans that cover 100%, 75%, or 50% after what Medicare pays.
- All medical plans provide coverage options nationwide or outside the U.S.
- Part D plans to help cover your prescriptions.
- Three dental plans from which to choose.
- 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.

Online:
Visit **www.pehp.org** and complete the online enrollment instructions (on Page 4).

First Time Enrolling?
Visit **www.pehp.org/US/enrollmedsup**

By Mail:
Complete the enclosed enrollment form (on Page 43) and send it to:

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

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.

Need Help Deciding?

Contact a Retiree Health Insurance Counselor at 801-366-7499.

2024 Highlights & Reminders

No Rate Increases

» We're happy to announce that there will be no rate increases in 2024 for PEHP medical and drug plans. Plus, all dental plans receive a rate decrease.

Changes to Deductibles and Out-of-Pocket Limits

» To follow Centers for Medicare and Medicaid Services (CMS) guidelines, the deductible will increase for all Part D plans and the out-of-pocket maximums will be higher for the Medical 50 and Medical 75 plans.

New Hearing Aid Benefit

» PEHP Medicare Supplement medical plans will have a new hearing aid benefit in 2024. See page 35 for details.

Earn Double Rewards

» We're increasing our AgeWell wellness rebate program by offering an extra $50 in 2024. This means you can earn a total of $100 just for participating in PEHP wellness activities. This extra incentive is our way of saying thank you for making your health a priority. Rebate info will be posted at **www.pehp.org/agewell**

More Wellness Activities & Prizes

» We're expanding our collection of wellness challenges, webinars, and online classes. Our newly launched "Wellness on Demand" site lets you choose your path to wellness at any time, from anywhere. Plus, you can earn monthly and annual prizes! Get started at **www.pehp.org/wellness**

Reminders

» If you forgot to select a dental plan, don't worry, you can still save 25% on your dental procedures by using the PEHP Discount Dental Benefit. Learn more on page 25.

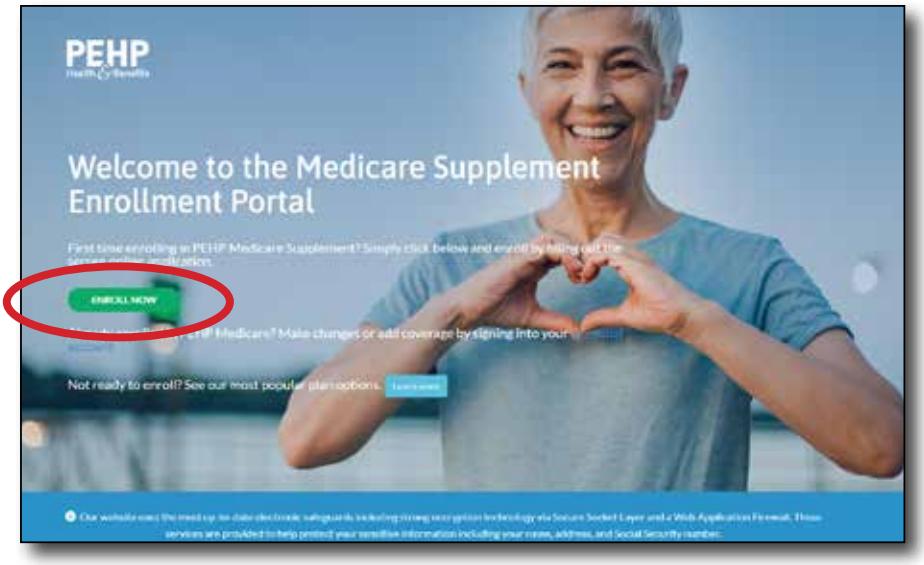
» **PEHP Member ID Number:** Be sure to provide your PEHP member ID number, which starts with "M000," when visiting providers to ensure accurate claims processing.

» **PEHP Online Account:** If you haven't already, create a PEHP online account to access your claims, find providers, view copays, deductibles, out-of-pocket max, benefits summary/master policy, and more. Plus, you can access a digital copy of your PEHP ID card. Create an account at www.pehp.org

OPEN ENROLLMENT: OCT. 15 – DEC. 7

Online Enrollment for New Members

Visit www.pehp.org/US/enrollmedsup and click green "Enroll Now" button.



Online Enrollment for Current Members

STEP 1: Log into your online account or create one at www.pehp.org.

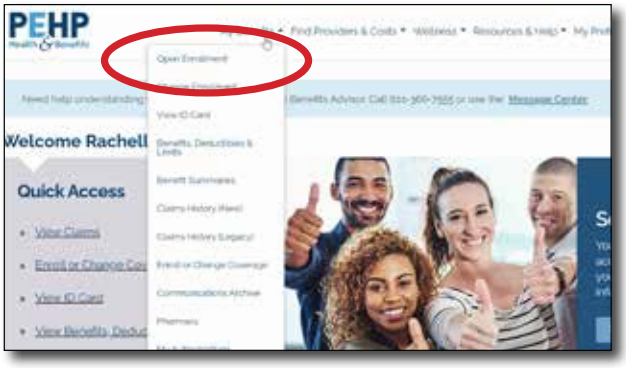
STEP 2: Once you log in, click on the My Benefits menu and select "Open Enrollment."

STEP 3: Click on "Edit coverage" to make plan changes.

STEP 4: You'll receive an enrollment confirmation.

For assistance with online enrollment, call 801-366-7410

For assistance with benefits, call 801-366-7555 or 800-765-7347



2024 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	$228.47	$138.38	$142.88	$147.38	$151.88	$156.38	$160.89	$165.39	$169.90	$174.41	$178.92
Plan 75	$176.01	$106.59	$110.05	$113.52	$116.99	$120.47	$123.95	$127.40	$130.87	$134.36	$137.82
Plan 50	$129.70	$78.52	$81.10	$83.65	$86.20	$88.77	$91.32	$93.88	$96.44	$99.00	$101.56

Monthly rates per person

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan 100	$183.41	$187.92	$192.43	$196.92	$201.43	$205.93	$210.44	$214.95	$219.46	$223.95	$228.47
Plan 75	$141.29	$144.77	$148.22	$151.70	$155.18	$158.64	$162.11	$165.60	$169.06	$172.53	$176.01
Plan 50	$104.11	$106.67	$109.25	$111.78	$114.35	$116.90	$119.47	$122.04	$124.58	$127.14	$129.70

Pharmacy Plans

Monthly rates per person

Basic	$45.35
Basic Plus	$66.20
Enhanced	$166.83
Employer Sponsored Enhanced Plan	$194.90

Vision Plans

Monthly rates per person

EyeMed - Full	$7.34
EyeMed - Eyewear Only	$6.36
Opticare - Full	$8.66
Opticare - Eyewear Only	$6.75

Dental Plans

Monthly rates per person

Dental 1500	$40.76
Dental 1000	$26.41
Basic Dental	$16.63

4 Ways to Pay Your Premium

Select the method of payment when you enroll online, or 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	100% of the Medicare eligible expenses	Nothing
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period. Medicare will cover an additional 60 lifetime reserve days for days 91 and beyond. PEHP 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 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 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.*

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	100% of the Medicare eligible expenses	Nothing
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period. Medicare will cover an additional 60 lifetime reserve days for days 91 and beyond. PEHP 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 $3,470. 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.*

Benefit Period: *Begins the day you are admitted 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 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.*

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 $3,470. 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 $3,470. 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	100% of the Medicare eligible expenses	Nothing
Note: Medicare will cover your stay in a hospital for up to 90 days in any given benefit period. Medicare will cover an additional 60 lifetime reserve days for days 91 and beyond. PEHP 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 $6,940. 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.*

Benefit Period: *Begins the day you are admitted 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 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.*

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 $6,940. 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 $6,940. 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: $545 *(combined for both retail and home delivery)*

Preventive medications (listed on Page 17) are not subject to the deductible.

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 $5,030.

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/ no maximum

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

Basic Drug Plan continued

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $5,030, you will pay the following until your yearly out-of-pocket drug costs reach $8,000.	
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 $8,000, you will pay nothing for covered Part D drugs.	

PEHP's Basic Prescription Drug Plan

The Basic Plan includes some preventive medications that are not subject to the deductible. This additional benefit for preventive medications may not normally be provided by a Medicare prescription drug plan. The preventive medication list includes Part D/eligible drugs that help prevent the recurrence or worsening of a disease and promote overall wellness.

Drugs currently included on the list are shown below, and include blood thinners, inhalers and anticoagulants. Please note that this list may change at any time.

Diabetes

METFORMIN PRODUCTS
glipizide-metformin
glyburide-metformin
metformin
metformin ER (non OSM, non MOD)
MISCELLANEOUS
pioglitazone
SULFONYLUREAS
glimepiride
glipizide
glipizide ER
glyburide
glyburide micronized

Depression

citalopram
escitalopram
fluoxetine
sertraline

Cardiovascular

ANTICOAGULANTS/ ANTIPLATELETS
clopidogrel
dipyridamole
warfarin
BETA BLOCKERS
acebutolol
bisoprolol
carvedilol
labetalol
metoprolol succinate
metoprolol tartrate
propranolol solution
propranolol tablets
sotalol
timolol maleate tablets
CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem
felodipine ER
isradipine
nifedipine tablets ER
COMBINATION PRODUCTS
amiloride & HCTZ
atenolol & chlorthalidone
bisoprolol & HCTZ
enalapril & HCTZ
irbesartan & HCTZ
lisinopril & HCTZ
losartan & HCTZ
metoprolol & HCTZ
spironolactone & HCTZ
propranolol & HCTZ
triamterene & HCTZ

RENIN/ANGIOTENSIN SYSTEM ANTAGONIST (ACEI/ARB)
enalapril
fosinopril
irbesartan
lisinopril
losartan
quinapril
ramipril
trandolapril
verapamil
verapamil ER
DIURETICS
amiloride
bumetanide
chlorothiazide
chlorthalidone
furosemide solution
furosemide tablets
hydrochlorothiazide capsules
hydrochlorothiazide tablets
indapamide
methazolamide
methyclothiazide
spironolactone
torsemide
MISCELLANEOUS
prazosin
clonidine
digoxin
VASODILATORS
hydralazine
isosorbide

Respiratory

ANTICHOLENERGICS
ipratropium bromide solution
INHALED CORTICOSTEROIDS
QVAR inhaler
SABA/ ANTICHOLENERGICS
ipratropium-albuterol inhaler
ipratropium-albuterol nebulized
SHORT ACTING BETA AGONISTS
albuterol ER tablets
albuterol nebulized
albuterol syrup
albuterol sulfate HFA inhaler
albuterol tablets

Osteoporosis

alendronate

Basic Plus Drug Plan

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(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 $5,030.

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/ no maximum

**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: $545 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $5,030, you will pay the following until your yearly out-of-pocket drug costs reach $8,000.	
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 $8,000, you will pay nothing for covered Part D drugs.	

Enhanced Drug Plan

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(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 $5,030.

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/ no maximum

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

Enhanced Drug Plan continued

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $5,030, you will pay no more than the cost-sharing amounts in the initial coverage stage until your yearly out-of-pocket drug costs reach $8,000.

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 $8,000, you will pay nothing for covered Part D drugs.

Employer-Sponsored Enhanced Drug Plan

Only available to members who receive a premium contribution to this Part D drug plan.

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(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 $5,030.

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.*

Employer-Sponsored Enhanced Drug Plan continued

Only available to members who receive a premium contribution to this Part D drug plan.

Plan pays balance after deductible and your co-insurance.

Annual Plan Deductible: $545 *(combined for both retail and home delivery)*

Coverage Gap Stage: After your total yearly drug costs reach $5,030, you will pay no more than the cost-sharing amounts in the initial coverage stage until your yearly out-of-pocket drug costs reach $8,000.
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 $8,000, you will pay nothing for covered Part D drugs.

Understanding the Coverage Gap

Most will not reach the Coverage Gap. When the total cost of your Part D drugs reaches $5,030, you move on to the Coverage Gap stage. The $5,030 includes the amount you have paid toward your deductible, your co-pays or co-insurance, 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 ($505)**	You've reached the **Coverage Gap**	You've reached your **Catastrophic benefit**
$0 to $545	**$545.01 to $5,030** *Total Drug Costs**	**$5,030.01 to $8,000**	**$8,000.01 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 nothing for covered Part D drugs

*** 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 Coverage 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/medsup.

DENTAL PLAN	Dental 1500	Dental 1000	Basic Dental	Discount Dental Benefit
Monthly Premium	$40.76	$26.41	$16.63	$0
Deductible	$0	$50	$50	$0
Annual Benefit Maximum	$1,500	$1,000	$500	$0
Benefits				
Preventive/ Cleaning	You pay $0	You pay 20% of in-network rate	You pay $0	You pay 100% 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	Not covered	You pay 100% of in-network rate*
Crown *Porcelain fused to high noble metal*	You pay 50% of in-network rate	You pay 50% of in-network rate after deductible	Not covered	You pay 100% of in-network rate*
Dental Network	Visit **www.pehp.org/providerlookup** for a complete list.			

**Use in-network PEHP dentist for discount.*

PEHP Discount Dental Benefit

When you enroll in a PEHP plan, you automatically have access to our Discount Dental Benefit at no extra cost. Enjoy an average 25% off dental services when using PEHP's dental network. PEHP will adjust the claim to the contracted discount rate and you pay for the service out-of-pocket. If you want dental coverage, consider enrolling in a PEHP Dental Plan. See pages 26-28 for details.

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	**$40.76**	
Deductible Does not apply to diagnostic or preventive services	**$0**	
Annual Benefit Max	**$1,500**	
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	**$0**	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**$0**	**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		
Periodontic cleanings, scaling and root planing	**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 are not eligible for six months from the date of PEHP coverage, unless you provide proof that you had other dental coverage in place for at least six consecutive months prior to enrolling.

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.

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	**$26.41**	
Deductible Does not apply to diagnostic or preventive services	**$50**	
Annual Benefit Max	**$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		
Periodontic cleanings, scaling and root planing	**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 are not eligible for six months from the date of PEHP coverage, unless you provide proof that you had other dental coverage in place for at least six consecutive months prior to enrolling.

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.

Basic Dental 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	**$16.63**	
Deductible (Does not apply to diagnostic or preventive services)	**$50**	
Annual Benefit Max	**$500**	
DIAGNOSTIC	**YOU PAY**	**YOU PAY**
Periodic Oral Exams	**$0**	**20%** of In-Network Rate AD*
X-rays	**$0**	**20%** of In-Network Rate AD
PREVENTIVE		
Cleanings and Fluoride Solutions	**$0**	**20%** of In-Network Rate AD
Sealants | Permanent molars only through age 17	**$0**	**20%** of In-Network Rate AD
RESTORATIVE		
Amalgam Restoration	**50%** of In-Network Rate AD*	**70%** of In-Network Rate AD
Composite Restoration	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD
ENDODONTICS		
Pulpotomy, Root Canal	Not covered	Not covered
PERIODONTICS		
Periodontic cleanings, scaling and root planing	Not covered	Not covered
ORAL SURGERY		
Extractions	Not covered	Not covered
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only		
General Anesthesia	Not covered	Not covered
PROSTHODONTIC BENEFITS		
Crowns, Bridges, Dentures	Not covered	Not covered
IMPLANTS		
All related services	Not covered	Not covered

*** AD** = After Deductible

OpticareVision services

Plan	Monthly Rate
Monthly	$8.66

OPTICARE PLAN – PEHP – Eye Exam & Hardware Benefits

0-10-150/140C

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

OpticareVision services

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

Plan	Monthly Rate
Monthly	$6.75

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

PEHP Full

40% OFF
additional complete pair of prescription eyeglasses

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

Find an eye doctor
(Insight Network)

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

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

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $30
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up – Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up – Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $100 allowance	Up to $50
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Progressive – Standard	$75 copay	Up to $40
Progressive – Premium Tier 1 - 3	$95 - 120 copay	Up to $40
Progressive – Premium Tier 4	$75 copay; 20% off retail price less $120 allowance	Up to $40
LENS OPTIONS		
Anti Reflective Coating – Standard	$45	Not covered
Anti Reflective Coating – Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating – Premium Tier 3	20% off retail price	Not covered
Photochromic – Non-Glass	$75	Not covered
Polycarbonate – Standard	$40	Not covered
Polycarbonate – Standard < 19 years of age	$40	Not covered
Scratch Coating – Standard Plastic	$15	Not covered
Tint – Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts – Conventional	$0 copay; 15% off balance over $120 allowance	Up to $96
Contacts – Disposable	$0 copay; 100% of balance over $120 allowance	Up to $96
Contacts – Medically Necessary	$0 copay; paid in full	Up to $200
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

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

PREMIUMS - monthly
Per person $7.34

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

PEHP Eyewear Only

40% OFF
additional complete pair of prescription eyeglasses

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

Find an eye doctor
(Insight Network)
- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

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

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Progressive – Standard	$75 copay	Up to $40
Progressive – Premium Tier 1 - 3	$95 - 120 copay	Up to $40
Progressive – Premium Tier 4	$75 copay; 20% off retail price less $120 allowance	Up to $40
LENS OPTIONS		
Anti Reflective Coating – Standard	$45	Not covered
Anti Reflective Coating – Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating – Premium Tier 3	20% off retail price	Not covered
Photochromic – Non-Glass	$75	Not covered
Polycarbonate – Standard	$40	Not covered
Polycarbonate – Standard < 19 years of age	$40	Not covered
Scratch Coating – Standard Plastic	$15	Not covered
Tint – Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts – Conventional	$0 copay; 15% off balance over $130 allowance	Up to $104
Contacts – Disposable	$0 copay; 100% of balance over $130 allowance	Up to $104
Contacts – Medically Necessary	$0 copay; paid in full	Up to $200
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

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

PREMIUMS - monthly
Per person $6.36

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

PEHPplus

Adding to Your Health

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

Visit **www.pehp.org/pehpplus** 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 hearing aids, eyewear, lasik, massages, spas, fitness classes, and more.

www.pehp.org/pehpplus

Health**Coaching**

Free Health Coaching Available to PEHP Medicare Supplement Members

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/weightmanagement

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

PEHP Health & Benefits

AgeWell Rebates for Seniors

You already make your health a priority. Why not get rewarded for it?

Earn $100 when you participate in PEHP wellness programs! Participate in personal health coaching, watch webinars on a variety of health topics, or sign up for wellness activities to help you create healthier habits and stay physically active.

LEARN MORE:
www.pehp.org/agewell

amplifon Hearing Health Care

PEHP Health & Benefits

Take care of your hearing health

It's good for your ears - and your overall health too!

When should I get my hearing checked?

Hearing changes come on so gradually that you may not even notice it's happening. We recommend you get your hearing tested, especially if you are experiencing any of the following:

- **Consistent exposure** to loud noises
- **Difficulty understanding** in noisy environments or in groups
- **Asking people to repeat themselves** or feeling like they are not speaking clearly
- **Ringing** in your ears

Your Hearing Program*

PEHP Health & Benefits has partnered with Amplifon to save members an average of 66% off MSRP** on hearing aids. Plus, you'll also enjoy a free hearing exam and:

Risk-free trial - find your right fit by trying your hearing aids for 60 days

Battery support - a charging station or battery supply to keep you powered

Follow-up care - ensures a smooth transition to your new hearing aids

Warranty - peace of mind with coverage for loss, repairs, or damage

Take the first step:

call 888-670-2307 TTY: 711 | Hours: Mon-Fri 6am - 7pm MT
or visit: www.amplifonusa.com/lp/pehpmedsupp

***Risk-free trial** - 100% money-back guarantee if not completely satisfied, no return or restocking fees. **Follow-up care** - for one year following purchase. **Batteries** - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. **Warranty** - for three years, exclusions and limitations may apply. Contact Amplifon 888-670-2307 for details. Amplifon Hearing Health Care, Corp. is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. PEHP Health & Benefits and Amplifon are independent, unaffiliated companies. The Amplifon Hearing Health Care discount program is not approved for use with any third-party payor program, including government and private third-party payor programs.

**Based on 2022 internal MSRP analysis. Your savings may vary.

IMPORTANT NOTICE FROM PEHP ABOUT PEHP's 2024 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 2024 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 2024 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 January 7, 2020

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, 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.

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. *Example: Your employer contracts with PEHP to provide a health plan, and PEHP provides your employer with certain statistics to explain the rates we charge.* For specific health information PEHP will only provide information 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

NAME (last, first, middle initial) AS APPEARS ON MEDICARE ID CARD		MEDICARE BENEFICIARY IDENTIFIER (MBI), AS APPEARS ON MEDICARE ID CARD	
SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED
HOME ADDRESS CITY/STATE/ZIP		PRIMARY PHONE	ALTERNATE PHONE
MAILING ADDRESS (*if different from Home Address*)		EMAIL ADDRESS	
PREVIOUS PUBLIC EMPLOYER		☐ Opt In For Online Explanations of Benefits (EOBs) Delivery	

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
- ☐ Employer-Sponsored Enhanced Plan *(Only available if you receive employer premium contributions)*
- ☐ No Coverage / Terminate Coverage

DENTAL

- ☐ Dental 1500 – $1,500 Annual Benefit Maximum
- ☐ Dental 1000 – $1,000 Annual Benefit Maximum
- ☐ Basic Dental – $500 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

Please make a copy for your records.

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** _____

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 BENEFICIARY IDENTIFIER (MBI), AS APPEARS ON MEDICARE ID CARD

HOME ADDRESS CITY/STATE/ZIP	PRIMARY PHONE	ALTERNATE PHONE

MAILING ADDRESS (*if different from Home Address*)	EMAIL ADDRESS
PREVIOUS PUBLIC EMPLOYER	☐ Opt In For Online Explanations of Benefits (EOBs) Delivery

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
- ☐ Employer-Sponsored Enhanced Plan *(Only available if you receive employer premium contributions)*
- ☐ No Coverage / Terminate Coverage

DENTAL

- ☐ Dental 1500 – $1,500 Annual Benefit Maximum
- ☐ Dental 1000 – $1,000 Annual Benefit Maximum
- ☐ Basic Dental – $500 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'S SPOUSE _____ DATE _____

Please make a copy for your records.

Free Presentations

PEHP Health & Benefits

Medicare presentations will be held in person and online.
Register at **pehp.org/medicaremeetings**.

Attend a PEHP online Medicare Open Enrollment Presentation to:

» Learn the Basics of Medicare

» Review PEHP's Medicare Supplement Plans

» Highlight Upcoming Changes to Medicare & PEHP for 2024

» Talk to a PEHP Representative and Ask Your Questions

URS
Utah Retirement Systems

PEHP
Health & Benefits

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

PRESORTED STANDARD
U.S. POSTAGE PAID
SALT LAKE CITY, UTAH
PERMIT NO. 4621

See inside for important benefit information

PEHP Medicare Supplement » Attend a free presentation.
See schedule online at **www.pehp.org/medicaremeetings**