PEHP
Health & Benefits

Medicare Supplement Master Policy

2023

1-24-23

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This Master Policy and corresponding Enrollment Guide is the contract between Public Employees Health Program (PEHP) and its Subscribers.

Recitals

This Master Policy between PEHP and its Subscribers is intended to comply with the provisions of Title 49, Chapter 20 of the Utah Code Annotated which creates the Public Employees Benefits and Insurance Program, also known as PEHP. The right and obligations of PEHP and its Subscribers are set forth in this Master Policy. If any term of this Master Policy is found to be in violation of Title 49, Chapter 20 of the Utah Code Annotated or any other state or federal law, or is unenforceable for any reason, that term shall be null and void and severable from the Master Policy and shall not render the Master Policy null and void as a whole. This contract is governed by, and will be interpreted and enforced according to the laws of the State of Utah.

This contract, including all matters incorporated herein, including, but not limited to, the Enrollment Guide and Enrollment forms, contains the entire agreement and it is binding upon Subscribers and their heirs, successors, personal representatives and assignees. There are no promises, terms, conditions, or obligations other than those contained herein. This contract supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Upon renewal of this contract, PEHP may modify rates, benefits, Exclusions, Limitations, and/or service by providing Subscriber with advance notice of change.

Paragraph headings appearing in this contract are not to be construed as interpretation of the text, but are only for the convenience of reference for the reader.

I. PEHP and Subscriber Responsibilities

1.1 CONTRACT AMENDMENTS

PEHP may unilaterally change this contract upon plan renewal and upon 60 days written notice to PEHP Subscribers.

1.2 AVAILABILITY OF CONTRACT FOR REVIEW

Subscribers are entitled to review a copy of this contract at www. pehp.org. Subscribers may also request a hard copy of this contract from PEHP.

1.3 NO VESTED RIGHTS

Subscribers are only entitled to receive benefits from PEHP while this contract is in effect. Subscribers do not have any permanent or vested interest in any benefits under this contract, and benefits may change or terminate as this contract is renewed, modified or terminated from year to year. Subscribers only have rights to benefits under this contract when they are properly enrolled and recognized by PEHP as Subscribers. Unless otherwise expressly stated in this contract, all benefits end when this contract ends. Subscribers have no right to receive any care, services, treatments, medications, supplies, or equipment from or through PEHP except in strict compliance with this entire contract.

1.4 ACCEPTANCE OF THIS CONTRACT

As a condition to receiving Coverage from PEHP, Subscribers are presumed and required to accept, comply with, and agree to, the terms of this contract.

1.5 PEHP DETERMINES ELIGIBLE SERVICES

Benefits under the Master Policy will be paid only if PEHP decides in its discretion that the Subscriber is entitled to them. PEHP also has discretion to determine eligibility for benefits, to require verification of any claim for Eligible Benefits and to interpret the terms and conditions of the benefit plan.

1.6 ADMINISTRATIVE PROVISIONS

PEHP will from time to time adopt and enforce reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of this Master Policy and in providing covered services to Subscribers.

Subscribers are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining covered services and other matters under this Master Policy.

1.7 COMPLIANCE RESPONSIBILITIES
Each party is responsible for its own compliance with applicable laws, rules and regulations.

1.8 CHANGES IN SUBSCRIBER CONTACT INFORMATION
It is the Subscriber's responsibility to keep PEHP informed of any change of address, phone number, and email address. Subscribers should keep copies of any notices sent to PEHP.

1.9 REQUESTS FOR INFORMATION
As a condition of receiving benefits under this Master Policy, Subscribers shall provide PEHP with all information at PEHP's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Subscriber to provide information to PEHP at PEHP's request under this section within a reasonable time, as determined by PEHP shall be a breach of this Master Policy and may result in forfeiture of benefits, termination of Coverage, or PEHP having the right to hold payment of claims for the Subscriber until the requested information is received by PEHP.

1.10 NOTICES
Any notice required of PEHP under this Master Policy will be sufficient if mailed by first class mail to the Subscriber at the address appearing on the records of PEHP. Any notice to PEHP will be sufficient if mailed to the principal office of PEHP in Salt Lake City, Utah.

1.11 RATE CHANGES
PEHP reserves the right to change premiums at any time, when actuarially indicated.

1.12 PEHP SUBSCRIBER RESPONSES
Without the consent of PEHP Administration, individual Subscribers of PEHP do not have the authority to:

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this Master Policy, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with PEHP requirements, such as the use of In-Network Providers or the necessity of obtaining Preauthorizations.

Benefits under this Master Policy are determined by and limited to provisions stated in this Master Policy. In the event that PEHP chooses to honor any Coverage or pay for any service mistakenly authorized or provided, such Coverage or payment will be limited to a maximum period of not more than thirty (30) days.

II. Definitions

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

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

BLOOD BENEFITS (PART B / OUTPATIENT)
In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or

replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.

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

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

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

CRITICAL ACCESS HOSPITAL
A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

CUSTODIAL CARE
Services, supplies, or accommodations for care rendered which:

1. Do not provide treatment of injury or illness;
2. Could be provided by persons without professional skills or qualifications;
3. Are provided primarily to assist a Subscriber in daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes; or
5. Maintain physical condition when there is no prospect of affecting remission or restoration of the Subscriber to a condition in which care would not be required.

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

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

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

IMMEDIATE FAMILY MEMBER
Immediate Family Members are considered to be (for purposes of this policy): the Subscriber, the spouse, child, parent, brother, sister, domestic partner, or anyone that lives in the same home or for which one party is dependent on the other for financial support of any Subscriber. Immediate Family Member includes any step-relatives of the same type as above.

INPATIENT REHABILITATION FACILITY
A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

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

LIFETIME RESERVE DAYS
In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance. See Section IV for coverage information beyond the 60 reserve days.

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

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

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

MEDICARE PART B EXCESS CHARGES
The additional amount a health care provider may charge above the Medicare-approved amount.

PREAUTHORIZATION
The process, prior to service, that the Subscriber and the treating Provider must complete in order to obtain authorization for benefits of this Master Policy for hospitalization. Preauthorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted. Preauthorization is valid only for the dates authorized, even if treatment has not been completed.

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

SPOUSE
The Subscriber's lawful spouse under Utah State Law. A valid marriage certificate and/or affidavit of marriage are required to demonstrate the validity of a marriage. Common-law marriage. A common law spouse is a lawful spouse under Utah State law, but only if the Subscriber and spouse obtains a court order establishing the common law marriage. Eligibility for a common-law spouse may not be established retroactively. General provisions relating to marriage. When a court order purports to retroactively either establish or annul/declare void a marriage or divorce for Benefit eligibility, PEHP will consider the marriage or dissolution of the marriage effective on the date the court order was signed by the court, or the date the order is received by PEHP, whichever is later.

SUBSCRIBER
A person enrolled in a PEHP Medicare Supplement plan whose premium is current.

URGENT CONDITION

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

III. Enrollment, Eligibility & Termination

3.1 GENERAL

Eligible Subscribers are required to enroll by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal. All information gathered and the information contained on the Enrollment form is incorporated into this contract. Any Enrollment or Coverage changes must be done in writing, by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal.

3.2 ELIGIBILITY

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

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

The PEHP Medicare Supplement Plan is available to:

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

The open enrollment period for PEHP's Medicare Supplement plans is October 15-December 7 with an effective date of January 1.

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

3.2.1 ENROLLMENT TIME PERIOD REQUIREMENTS

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

Enrollment

Current Subscribers can make changes during open enrollment online at www.pehp.org. New Subscribers need to complete and return an enrollment form to:
PEHP
Enrollment Department
560 East 200 South
Salt Lake City, Utah 84102-2004

3.2.2 SPECIAL ENROLLMENT PERIODS

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

A few examples are:

- Entering or leaving a skilled nursing facility.
- Enrolling in, or disenrolling from, a Medicare Advantage plan that has a prescription drug benefit.
- Your current plan no longer offers Medicare prescription drug coverage.

If you do not meet the Medicare Special Enrollment criteria, you will be unable to re-enroll until October 15, through December 7, for coverage effective January 1.

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

In addition to the Medicare Special Enrollment Periods, there are Special Enrollment Periods under the PEHP Medicare Supplement Plans.

They are:

- Disenrolling in a Medicare Advantage plan anytime between January 1 and March 31 each year.
- At any time throughout the year if you are able to secure Medicare parts A and B.

In either case, the enrollment time period is 30 days from the date of the qualifying event.

If you have questions regarding the PEHP Special Enrollment Periods, please contact Customer Service at 801-366-7555 or 1-800-955-7347.

3.3 TERMINATION OF COVERAGE

Disenrollment Guidelines – Medical

- **Voluntary Disenrollment**
  You may disenroll from PEHP's Medicare Supplement Medical Plan during one of the election periods by providing a signed, written notice to PEHP. Failure to pay premiums will also result in disenrollment.

Disenrollment Guidelines – Drug

- **Voluntary Disenrollment**
  You may disenroll from a prescription drug plan during one of the election periods by doing the following:
  - Providing a signed, written notice to PEHP.
  - Giving a signed, written notice to any Social Security Administration or Railroad Retirement Board office.
  - Calling Medicare at 800-633-4227 (TTY/TDD 877-486-2048) to disenroll.

  Failure to pay premiums will also result in disenrollment.

- **Required Involuntary Disenrollment for PEHP's Prescription Drug Plans**
  PEHP is required to disenroll a Subscriber in the following cases:
  - The Subscriber loses entitlement to Medicare.
  - The Subscriber dies.
  - The prescription drug plan contract is terminated or the organization discontinues offering a plan in any portion of the area where it has previously been available.
  - The Subscriber materially misrepresents information to the prescription drug plan organization regarding reimbursement for third-party coverage.
  - The Subscriber enrolls in another Medicare Advantage Plan or Medicare Part D plan.

» **Involuntary Disenrollment for Disruptive Behavior**
"Disruptive behavior" is behavior that substantially impairs the prescription drug plan's ability to arrange or provide care to the disruptive Subscriber or other plan Subscribers.

» **Medicare Supplement Disclaimer**
PEHP's Basic, Basic Plus and Enhanced prescription drug plans are creditable. If you decide to join a different prescription drug plan through another Medicare supplement plan through another carrier, you must contact PEHP.

3.4 COORDINATION OF BENEFITS

Auto Insurance/No-Fault

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

Correction of Payment in Error

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

Multiple Coverages

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

Here are answers to common questions you might have:

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

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

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

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

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

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

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

3.5 PREMIUMS AND SUBSIDIES

Medicare Premiums

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

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

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

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

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

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

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

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

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

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

IV. Medical Benefits

4.1 PEHP MEDICARE SUPPLEMENT MEDICAL URGENT AND EMERGENT OUT-OF-COUNTRY COVERAGE

Medicare Parts A and B do not offer coverage for services while you are traveling outside the United States. However, your PEHP Medicare Supplement Medical Plan does offer coverage for these services, up to $50,000 per lifetime in accordance with Utah Code annotated R59/146-8a.C(6). If you receive Urgent or Emergent medical care in another country, allowable fees will be eligible billed charges. A copy of the original foreign claim must be submitted along with documentation proving payment. PEHP will determine the urgent or emergent status of each claim submitted for reimbursement. Please refer to the benefits grids for more information. Out of country prescription drug claims are not eligible for reimbursement.

4.2 PEHP MEDICARE SUPPLEMENT PLANS

PEHP's plans will only consider payment for services that are eligible under Medicare and there are limitations on certain services. Contact Medicare for a complete list of eligible services. PEHP's plans include coverage for Part B Excess Charges. Coverage is based on the plan you select. Part B Excess Charges, are charges from your physician above the Medicare-approved amount. Many physicians DO accept the Medicare-approved amount; however, some may not. All plans provide Benefits for out-of-country coverage as described in Section 4.1 above.

PEHP does not pay for any drugs for which Medicare does not pay.

4.3 PEHP MEDICARE SUPPLEMENT– COVERAGE BEYOND THE 60 LIFETIME RESERVE DAYS

Once lifetime reserve days are used, PEHP will pay a percentage of Medicare-eligible hospital expenses depending on the plan, up to an additional 365 lifetime days, of which up to 190 days can be used for mental health. All inpatient stays utilizing this benefit must be Preauthorized. The Subscriber will also be responsible for a percentage of the expenses.

4.4 PEHP MEDICARE PRESCRIPTION DRUG PLANS

PEHP Medicare Prescription Drug Plans include coverage for:

- Immunizations, except those covered under Medicare Part B preventive Benefits.
- A list of covered drugs called the formulary.

  It tells which Part D prescription drugs are covered by Express Scripts Medicare. The preferred brand-name and non-preferred drugs on this list are selected by the plan with the help of a team of doctors and pharmacists and meet requirements set by Medicare.
- Express Scripts may contact you if you are taking a drug that is not on the formulary. If the formulary changes, affected Subscribers will be notified in writing by Express Scripts before the change is effective. PEHP offers three Medicare Part D approved prescription drug plans. The difference between the three plans is the level of coverage for prescription drugs.

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

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

You have the choice of filling your retail prescriptions at pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within our network.

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

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

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

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

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

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

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

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

4.4 MANDATED MEDICARE DRUG EXCLUSIONS

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

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

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

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs when used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and benzodiazepines

4.5 DRUG UTILIZATION MANAGEMENT

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

- **Prior Authorization**
  Approval in advance to get certain drugs that may or may not be on the formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. If you don't receive this approval, Express Scripts Medicare may not pay for your prescription.
- **Quantity Limits**
  A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
- **Generic Drug**
  A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.
- **Generic Substitution**
  When there is a generic version of a brand name drug available, our participating pharmacies will automatically give you the generic version, unless your doctor has specified that you must take the brand name drug.

4.6 COVERAGE LIMITS AND APPEALS

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

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

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

4.7 SERVICE AND COMPLAINTS

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

- Call Express Scripts Customer Service at 800-590-2239 (TTY/TDD 800-716-3231).
- Complete a Service and Complaint Form on the Express Scripts website: www.express-scripts.com.
- Write to the Express Scripts Service and Complaints Department:

  Express Scripts Health Solutions, Inc.
  Attn: Service Grievance Resolution Team
  P.O. Box 639405
  Irving, Texas 75063

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

4.8 MEDICARE COVERAGE GAP

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

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

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

V. PEHP Discount Dental Plan

5.1 PEHP DISCOUNT DENTAL PLAN

Value-Added Dental Plan

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

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

The average savings you will receive when services are performed by an in-network dentist is 25% off the billed amount. Costs may vary if a specialist provides the services. Costs are subject to change.

Payment at the time of service is up to the discretion of the in-network provider.

Discount Dental Plan Features

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

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

- Orthodontia
- Cosmetic Surgery

» TMJ

» Services that are performed by an out-of-network provider.

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

VI. Claims Submission & Appeals

6.1 CLAIMS SUBMISSION

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

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.