

Notes & Reminders

- » Because you're on Medicare, **you're not eligible for the federal marketplace or the exchanges.**
- » See new **rates** on Page 2.
- » Monthly premiums can be deducted from your **URS retirement check.**
- » You get **out-of-state** coverage.
- » You get **out-of-country** coverage for urgent and emergent care only.
- » Medical Plans include a **Discount Dental Benefit**, which gives you access to PEHP's dental discounts.
- » Check out PEHP's **discounts** on healthy lifestyle products and services (www.pehp.org/plus).



	Page
Overview of plans and rates	2
Enrollment and contact information	3
Medical plan benefits	4-9
Prescription drug plan benefits.....	10-16
Discount dental benefits.....	17
Online enrollment.....	18
Enrollment form	19-20

PEHP Medicare Supplement Plans

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

- » We offer three supplement medical plans and three pharmacy plans. You may enroll in just a medical plan, just a pharmacy plan, or both.
- » All plans provide coverage for Medicare Part A and Medicare Part B deductibles, copayments and for Medicare Part B Excess Fees.
- » All plans provide medical coverage while you are traveling outside of the United States.
- » Medical Plans include Discount Dental, which gives you access to PEHP's dental discounts, saving you as much as 25%.



Monthly Rates (Effective January 1, 2015):

Plan Choice	Monthly Cost
Basic Prescription Drug Plan only	\$32.85 per person
Basic Plus Prescription Drug only	\$46.00 per person
Enhanced Prescription Drug only	\$108.85 per person
Medicare Supplement Medical Plan 100	\$148.00 per person
Medicare Supplement Medical Plan 75	\$114.00 per person
Medicare Supplement Medical Plan 50	\$84.00 per person

9/24/14

How to Enroll & Make Changes

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

If you want to make changes, you will need to do so by Dec. 7.

You can make changes online at www.pehp.org (instructions on page 18), or complete and mail the enrollment form in the back of this book.

Mail to:

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

To Get More Information

Learn more about Medicare and PEHP Medicare Supplement by attending a free PEHP presentation (see inside cover for the schedule).

For additional information about PEHP Medicare Supplement plans, see the PEHP Medicare Supplement Master Policy. To get a copy, email publications@pehp.org or call PEHP.

Contact Information

PEHP

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

www.pehp.org

Customer Service:

801-366-7555 or 800-765-7347

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

Medicare Administration

www.medicare.gov

800-633-4227

(TTY/TDD 877-486-2048)

Prescription Benefits (Medicare Part D)

Express Scripts

PO Box 2016

Pine Brook, NJ 07058-2016

www.express-scripts.com

Customer Service: 800-590-2239

(TTY/TDD 800-716-3231)

Social Security Administration

www.ssa.gov

800-772-1213

(TTY/TDD 800-325-0778)

Medical Plan 100

Medicare Part A	Medicare Pays	PEHP Plan Pays	You Pay
Inpatient Hospital Services – Per Benefit Period <i>Semi-private room and board, miscellaneous expenses</i>			
First 60 Days	All approved charges after the Medicare Deductible for the first 60 days	100% of the Medicare Deductible for the first 60 days	Nothing
Days 61 to 90	All approved charges, except for the Medicare Copayment for days 61 to 90	100% of the Medicare Copayment for days 61 to 90	Nothing
91 Days & Beyond <i>While using your 60 lifetime reserve days</i>	All approved charges, except for the Medicare Copayment per "lifetime reserve day" for days 91 and beyond	100% of the Medicare Copayment per day for each "lifetime reserve day" and 90% of eligible expenses for days 151 and beyond	Balance
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 100 benefits and Medicare's eligible fees.			
Blood			
Whole Blood	100% of Medicare-approved allowance after first three pints each calendar year	100% of the first three pints of blood	Nothing
Skilled Nursing Facility <i>Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital</i>			
First 20 Days	100% of Medicare approved charges	Nothing	Nothing
Days 21 to 100	100% of approved charges, except for the Medicare Copayment per day	100% of the Medicare Copayment per day	Nothing
Day 101 & Beyond	No Benefits are payable	No Benefits are payable	100%

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

Medical Plan 100

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i>			
Deductible	Not a covered benefit	100% of the Medicare deductible	Nothing
Approved Charges	80% of Medicare approved charges, after the Medicare deductible	20% of Medicare approved charges, after the Medicare deductible	Nothing
Excess Charges <i>Above Medicare approved amounts</i>	Nothing	100% of the Medicare Part B excess charges	Nothing
Mental Health Services <i>Outpatient treatment (Benefits may vary)</i>			
Diagnosis <i>of your condition</i>	80% of Medicare approved charges, after the Medicare deductible	20% of Medicare approved charges, after the Medicare deductible	Nothing
Services Outside the United States <i>For Urgent and Emergent Care only</i>			
Inpatient Hospital <i>No day limit. Includes ancillary charges</i>	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 <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i>	Not a covered benefit	80% of billed charges	Balance
Ambulance	Not a covered benefit	80% of billed charges	Balance
Prescription Drugs	Out-of-Country prescriptions are not eligible under the policy.		

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) <i>Semi-private room and board, miscellaneous expenses</i>			
First 60 Days	All approved charges after the Medicare Deductible for the first 60 days	75% of the Medicare Deductible for the first 60 days	25% of the Medicare Deductible ♦
Days 61 to 90	All approved charges, except for the Medicare Copayment for days 61 to 90	75% of the Medicare Copayment for days 61 to 90	25% of the Medicare Copayment ♦
91 Days & Beyond <i>While using your 60 lifetime reserve days</i>	All approved charges, except for the Medicare Copayment per “lifetime reserve day” for days 91 and beyond	75% of the Medicare Copayment per day for each “lifetime reserve day” and 75% of eligible expenses for days 151 and beyond	25% of the Medicare Copayment per day for each “lifetime reserve day” and 25% of eligible expenses for days 151 and beyond ♦
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 75 benefits and Medicare’s eligible fees.			
Blood			
Whole Blood	100% of Medicare-approved allowance after first three pints each calendar year	75% of the first three pints of blood	25% of the first three pints of blood ♦
Skilled Nursing Facility <i>Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital</i>			
First 20 Days	100% of Medicare approved charges	Nothing	Nothing
Days 21 to 100	100% of approved charges, except for the Medicare Copayment per day	75% of the Medicare Copayment per day	25% of the Medicare Copayment per day ♦
Day 101 & Beyond	No Benefits are payable	No Benefits are payable	100%

♦ Applies to the annual out-of-pocket maximum limit of \$2,470*.

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

Medical Plan 75

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i>			
Deductible	Not a covered benefit	75% of the Medicare deductible	25% of the Deductible ♦
Approved Charges	80% of Medicare approved charges, after the Medicare deductible	15% of Medicare approved charges, after the Medicare deductible	5% of Medicare approved charges, after deductible ♦
Excess Charges <i>Above Medicare approved amounts</i>	Nothing	75% of the Medicare Part B excess charges	25% of the Medicare Part B excess charges
Mental Health Services <i>Outpatient treatment (Benefits may vary)</i>			
Diagnosis 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 <i>For Urgent and Emergent Care only</i>			
Inpatient Hospital <i>No day limit. Includes ancillary services</i>	Not a covered benefit	75% of billed charges, up to \$700 per day	Balance or 25% after \$700 per day
Outpatient Hospital Room Charges <i>Including ER</i>	Not a covered benefit	75% of billed charges	Balance
Surgeon/Surgical Services	Not a covered benefit	75% of billed charges	Balance
Other Physician/ Professional Services <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i>	Not a covered benefit	75% of billed charges	Balance
Ambulance	Not a covered benefit	75% of billed charges	Balance
Prescription Drugs	Out-of-Country prescriptions are not eligible under the policy.		

♦ Applies to the annual out-of-pocket maximum limit of \$2,470*.

*Coinsurance 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) <i>Semi-private room and board, miscellaneous expenses</i>			
First 60 Days	All approved charges after the Medicare Deductible for the first 60 days	50% of the Medicare Deductible for the first 60 days	50% of the Medicare Deductible ♦
Days 61 to 90	All approved charges, except for the Medicare Copayment for days 61 to 90	50% of the Medicare Copayment for days 61 to 90	50% of the Medicare Copayment ♦
91 Days & Beyond <i>While using your 60 lifetime reserve days</i>	All approved charges, except for the Medicare Copayment per “lifetime reserve day” for days 91 and beyond	50% of the Medicare Copayment per day for each “lifetime reserve day” and 50% of eligible expenses for days 151 and beyond	50% of the Medicare Copayment per day for each “lifetime reserve day” and 50% of eligible expenses for days 151 and beyond ♦
Note: Once lifetime reserve days are used, benefits will continue to be paid based on Plan 50 benefits and Medicare’s eligible fees.			
Blood			
Whole Blood	100% of Medicare-approved allowance after first three pints each calendar year	50% of the first three pints of blood	50% of the first three pints of blood ♦
Skilled Nursing Facility <i>Short-term, non-custodial care only; Confinement must follow a three-day stay in the hospital</i>			
First 20 Days	100% of Medicare approved charges	Nothing	Nothing
Days 21 to 100	100% of approved charges, except for the Medicare Copayment per day	50% of the Medicare Copayment per day	50% of the Medicare Copayment per day ♦
Day 101 & Beyond	No Benefits are payable	No Benefits are payable	100%

♦ Applies to the annual out-of-pocket maximum limit of \$4,940*.

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

Medical Plan 50

Medicare Part B	Medicare Pays	PEHP Plan Pays	You Pay
Medical Expenses <i>Inpatient and outpatient physician's services, surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</i>			
Deductible	Not a covered benefit	50% of the Medicare deductible	50% of deductible ♦
Approved Charges	80% of Medicare approved charges, after the Medicare deductible	10% of Medicare approved charges, after the Medicare deductible	10% of Medicare approved charges, after deductible ♦
Excess Charges <i>Above Medicare approved amounts</i>	Nothing	50% of the Medicare Part B excess charges	50% of the Medicare Part B excess charges
Mental Health Services <i>Outpatient treatment (Benefits may vary)</i>			
Diagnosis <i>of your condition</i>	80% of Medicare approved charges, after the Medicare deductible	10% of Medicare approved charges, after the Medicare deductible	10% of Medicare approved charges, after deductible ♦
Services Outside the United States <i>For Urgent and Emergent Care only</i>			
Inpatient Hospital <i>No day limit. Includes ancillary services</i>	Not a covered benefit	50% of billed charges, up to \$700 per day	Balance, or 50% after \$700 per day
Outpatient Hospital Room Charges <i>Including ER</i>	Not a covered benefit	50% of billed charges	Balance
Surgeon/Surgical Services	Not a covered benefit	50% of billed charges	Balance
Other Physician/ Professional Services <i>(Office visits, Diagnostic Lab and X-ray Services, etc.)</i>	Not a covered benefit	50% of billed charges	Balance
Ambulance	Not a covered benefit	50% of billed charges	Balance
Prescription Drugs	Out-of-Country prescriptions are not eligible under the policy.		

♦ Applies to the annual out-of-pocket maximum limit of \$4,940*.

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

For additional information, see the PEHP Medicare Supplement Master Policy

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

Annual Plan Deductible: \$320 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,960.

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

Basic Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$320 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,960, you will pay the following until your yearly out-of-pocket drug costs reach \$4,700.

Brand Drugs	45% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference.)
Generic Drugs	65% of the plan's costs for all covered generic drugs.

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,700, you will pay the greater of 5% coinsurance or the following.

Retail	» a \$2.65 copayment for covered generic drugs (including brand drugs treated as generics) » a \$6.60 copayment for all other covered drugs.			
Mail Order	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	\$2.65 minimum/ \$75 maximum	\$6.60 minimum/ \$100 maximum	\$6.60 minimum/ no maximum	\$2.65 minimum for generics and \$6.60 minimum for brand drugs, with maximums of: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$375

Basic Plus Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$320 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,960.

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

Basic Plus Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$320 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,960, you will pay the following until your yearly out-of-pocket drug costs reach \$4,700.

Brand Drugs	45% of the cost of covered Medicare Part D brand drugs, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference.)
Generic Drugs	The same copayment/coinsurance as in the Initial Coverage stage for Tier 1 Generic Drugs and 65% of the plan's costs for all other covered generic drugs.

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,700, you will pay the greater of 5% coinsurance or the following.

Retail	» a \$2.65 copayment for covered generic drugs (including brand drugs treated as generics) » a \$6.60 copayment for all other covered drugs.			
Mail Order	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	\$2.65 minimum/ \$75 maximum	\$6.60 minimum/ \$100 maximum	\$6.60 minimum/ no maximum	\$2.65 minimum for generics and \$6.60 minimum for brand drugs, with maximums of: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$450

Enhanced Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$320 (combined for both retail and mail)

Initial Coverage Stage: After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach \$2,960.

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

Enhanced Drug Plan

Plan pays balance after Deductible and your coinsurance.

Annual Plan Deductible: \$320 (combined for both retail and mail)

Coverage Gap Stage: After your total yearly drug costs reach \$2,960, you will pay no more than the cost-sharing amounts in the Initial Coverage stage until your yearly out-of-pocket drug costs reach \$4,700.

Catastrophic Coverage Stage: After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,700, you will pay the greater of 5% coinsurance or the following.

Retail	<ul style="list-style-type: none"> » a \$2.65 copayment for covered generic drugs (including brand drugs treated as generics) » a \$6.60 copayment for all other covered drugs. 			
Mail Order	Generic Drugs (including brand drugs treated as generics):	Preferred Brand Drugs:	Non-Preferred Brand Drugs:	Specialty Tier Drugs:
	\$2.65 minimum/ \$75 maximum	\$6.60 minimum/ \$100 maximum	\$6.60 minimum/ no maximum	\$2.65 minimum for generics and \$6.60 minimum for brand drugs, with maximums of: 0-31 days: \$150 32-60 days: \$300 61-90 days: \$450

Understanding the Coverage Gap

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

How the Coverage Gap Works

As your yearly drug spending increases, your benefit changes

	You've met your Deductible (\$320)	You've reached the Coverage Gap	You've reached your Catastrophic benefit
<p>0 to \$320 <i>Out-of-Pocket</i></p> <p>You pay all expenses out-of-pocket</p>	<p>\$320.01 to \$2,960 <i>Total Drug Costs*</i></p> <p>You pay according to the plan benefits</p>	<p>\$2,960.01 to \$4,700</p> <p>You pay . . .</p> <p>Basic: 65% for generic, 45% for brand name.</p> <p>Basic Plus: Copayment for generic, 45% for brand name**</p> <p>Enhanced: No coverage gap</p>	<p>\$4,700.01 and up <i>Out-of-Pocket</i></p> <p>You pay according to the plan benefits</p>

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

** Plus a portion of the dispensing fee.

PEHP Discount Dental Benefits

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

You'll get discounts on dental services when you see dentists in the PEHP network (find them at www.pehp.org or by calling PEHP).

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

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

Online Enrollment Instructions

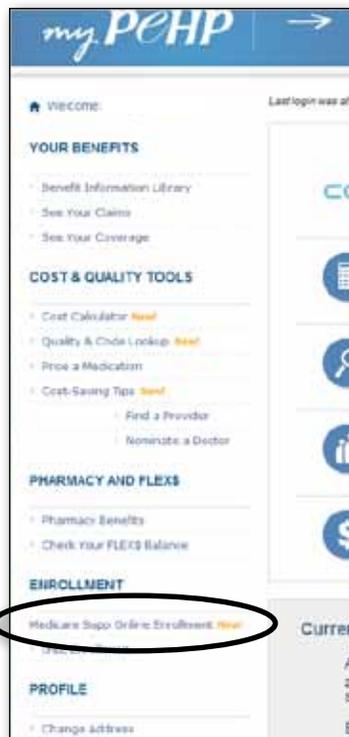
To help better serve you, Online Enrollment is now available for existing PEHP Medicare Supplement members. You can make any enrollment changes online during this open enrollment period (October 15 – December 7). You can also fill out paper enrollment forms to make changes if that is easier for you. Those forms are attached in this book.

If you are not making changes, no action is necessary. Your current coverage will remain in effect for 2014.

For changes, follow the steps below for online enrollment:

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

STEP 2: Once you log in, you will be directed to the myPEHP main page. During the open enrollment period, you will have access to online enrollment link shown here on the menu at left.



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

STEP 4: Click on the “Enroll/Change” button to make plan changes to either your medical or pharmacy coverage. If you are not making changes simply verify that the coverage you have is accurate.

STEP 5: When you are finished with changes, you will have the opportunity to carefully review your information. After you have read the terms and conditions, signify that you agree by typing your name exactly as shown. You must use all capital letters and punctuation if displayed.

STEP 6: You will receive an enrollment confirmation. Click “Print” for a print-formatted PDF. This confirmation is for your personal records. Return to the landing page to make additional changes.

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



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

Medicare Supplement Plan Enrollment and Record Card

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

Reason for enrollment change _____

Retiree Information

Spouse Information on Reverse

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

CURRENT MEDICARE COVERAGE

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

Do you currently have other non-PEHP medical coverage? Yes No

If yes, provide company name _____ Termination Date _____

PLAN SELECTION

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

No Coverage / Terminate Coverage

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

 Signature of Retired Employee _____
 Date

Authorization To Deduct Premiums

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

- Deduct Medical Premiums from Retirement Check
 Bill Me for Monthly Premiums

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

 Signature Of Retired Employee _____
 Date

Spouse Information

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

CURRENT MEDICARE COVERAGE

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

Do you currently have other non-PEHP medical coverage? Yes No

If yes, provide company name _____ Termination Date _____

PLAN SELECTION

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

MEDICAL

PHARMACY

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

Basic Pharmacy

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

Basic Plus Pharmacy

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

Enhanced Pharmacy

No Coverage / Terminate Coverage

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

Signature of Retired Employee

Date

Dependent Information

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

CURRENT MEDICARE COVERAGE

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

Do you currently have other non-PEHP medical coverage? Yes No

If yes, provide company name _____ Termination Date _____

PLAN SELECTION

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

MEDICAL

PHARMACY

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

Basic Pharmacy

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

Basic Plus Pharmacy

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

Enhanced Pharmacy

No Coverage / Terminate Coverage

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

Signature of Retired Employee

Date

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