

# 2016 Summary of Benefits

HMO Plan  
Pennsylvania  
H3907



## Multi-Language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-539-3080. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-539-3080. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-539-3080。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-539-3080。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-539-3080. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-539-3080. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-539-3080 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-539-3080. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-539-3080 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-539-3080. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-539-3080. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-539-3080 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-539-3080. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-539-3080. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-539-3080. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-539-3080. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-539-3080にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

# SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **UPMC for Life HMO, HMO Deductible with Rx, HMO Rx, or HMO Rx Enhanced (HMO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **UPMC for Life HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Sections in this booklet

- Things to Know About **UPMC for Life HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-877-539-3080. TTY users should call 1-800-361-2629.

## Things to Know About UPMC *for Life* HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)

### Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday from 8:00 a.m. to 8:00 p.m. Eastern time, Tuesday from 8:00 a.m. to 8:00 p.m. Eastern time, Wednesday from 8:00 a.m. to 8:00 p.m. Eastern time, Thursday from 8:00 a.m. to 8:00 p.m. Eastern time, Friday from 8:00 a.m. to 8:00 p.m. Eastern time, Saturday from 8:00 a.m. to 3:00 p.m. Eastern time.

### UPMC *for Life* HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-877-539-3080. TTY users should call 1-800-361-2629.
- If you are not a member of this plan, call toll-free 1-877-381-3765. TTY users should call 1-800-361-2629.
- Our website: [www.upmchealthplan.com/medicare](http://www.upmchealthplan.com/medicare)

### Who can join?

To join **UPMC *for Life* HMO** or **HMO Deductible with Rx (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland in our Western Pennsylvania region and Lancaster in our Lancaster region.

To join **UPMC *for Life* HMO Rx** or **HMO Rx Enhanced (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland.

## Which doctors, hospitals, and pharmacies can I use?

**UPMC for Life HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider directory at our website ([www.upmchealthplan.com/medicare](http://www.upmchealthplan.com/medicare)).

You can see our plan's pharmacy directory at our website (<https://www.upmchealthplan.com/medicare/documents-and-forms/>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs for **UPMC for Life HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)**. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <https://www.upmchealthplan.com/medicare/documents-and-forms/>.
- Or, call us and we will send you a copy of the formulary.

**UPMC for Life HMO (HMO)** covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

## How will I determine my drug costs?

**UPMC for Life HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)** group each medication into one of five “tiers.” You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.



## SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

	<i>UPMC for Life</i> HMO (HMO)	<i>UPMC for Life</i> HMO Deductible with Rx (HMO)
<b>MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</b>		
<b>How much is the monthly premium?</b>	<p>\$0 per month. In addition, you must keep paying your Medicare Part B premium.</p> <p>For Lancaster County members, UPMC Health Plan will reduce your Medicare Part B premium by up to \$46.20.</p>	<p>\$0-\$22 per month. In addition, you must keep paying your Medicare Part B premium.</p> <p>Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.</p>
<b>How much is the deductible?</b>	<p>This plan does not have a deductible.</p>	<p>This plan has deductibles for some hospital and medical services.</p> <p>\$750 per year for in-network services.</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$3,400 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$4,000 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit on how much the plan will pay?</b>	<p>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</p>	<p>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</p>

UPMC *for Life* has a contract with Medicare to provide HMO and PPO plans. Enrollment in UPMC *for Life* depends on contract renewal. UPMC *for Life* is a product of and operated by UPMC Health Plan Inc., UPMC Health Benefits Inc., and UPMC Health Network Inc.



<p align="center"><b>UPMC <i>for Life</i> HMO Rx (HMO)</b></p>	<p align="center"><b>UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</b></p>
<p>\$83 per month. In addition, you must keep paying your Medicare Part B premium.</p>	<p>\$242 per month. In addition, you must keep paying your Medicare Part B premium.</p>
<p>This plan does not have a deductible.</p>	<p>This plan does not have a deductible.</p>
<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$3,400 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$3,400 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<p>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</p>	<p>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</p>

**COVERED MEDICAL AND HOSPITAL BENEFITS**

**Note:**

- Services with a <sup>1</sup> may require prior authorization.

**OUTPATIENT CARE AND SERVICES**

<b>Acupuncture</b>	Not covered	Not covered
<b>Ambulance</b>	\$125 copay per one-way trip	\$100 copay per one-way trip (after you pay your deductible)
<b>Chiropractic Care</b>	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay  Routine chiropractic visit (for up to 6 every year): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
<b>Dental Services</b>	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$45 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$50 copay  Preventive dental services: • Dental x-ray(s) (for up to 1 every year): \$15 copay  Dental services: \$15 copay for a single office visit that includes: • Cleaning (for up to 1 every six months) • Oral exam (for up to 1 every six months)

UPMC <i>for Life</i> HMO Rx (HMO)	UPMC <i>for Life</i> HMO Rx Enhanced (HMO)
Not covered	Not covered
\$200 copay per one-way trip	\$100 copay per one-way trip
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
Routine chiropractic visit (for up to 6 every year): \$20 copay	Routine chiropractic visit (for up to 6 every year): \$20 copay
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$40 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$25 copay
Preventive dental services: <ul style="list-style-type: none"> <li>Dental x-ray(s) (for up to 1 every year): \$15 copay</li> </ul>	Preventive dental services: <ul style="list-style-type: none"> <li>Dental x-ray(s) (for up to 1 every year): \$15 copay</li> </ul>
Dental services: \$15 copay for a single office visit that includes: <ul style="list-style-type: none"> <li>Cleaning (for up to 1 every six months)</li> <li>Oral exam (for up to 1 every six months)</li> </ul>	Dental services: \$15 copay for a single office visit that includes: <ul style="list-style-type: none"> <li>Cleaning (for up to 1 every six months)</li> <li>Oral exam (for up to 1 every six months)</li> </ul>

	<b>UPMC <i>for Life</i> HMO (HMO)</b>	<b>UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</b>
<b>Diabetes Supplies and Services</b>	<p>Diabetes monitoring supplies: 20% of the cost</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.</p>	<p>Diabetes monitoring supplies: 20% of the cost</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.</p> <p>(Diabetes monitoring supplies and therapeutic shoes or inserts: after you pay your deductible)</p>
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b> <i>(Costs for these services may be different if received in an outpatient surgery setting)</i> <sup>1</sup>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$110 copay</p> <p>Diagnostic tests and procedures: \$0-5 copay, depending on the service</p> <p>Lab services: \$0-5 copay, depending on the service</p> <p>Outpatient x-rays: \$30 copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): \$25 copay</p>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$100 copay</p> <p>Diagnostic tests and procedures: \$0-10 copay, depending on the service</p> <p>Lab services: \$0-10 copay, depending on the service</p> <p>Outpatient x-rays: \$10 copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p> <p>(Diagnostic and therapeutic radiology services, and outpatient x-rays: after you pay your deductible)</p>
<b>Doctor's Office Visits</b>	<p>Primary care physician visit: \$5 copay</p> <p>Specialist visit: \$45 copay</p>	<p>Primary care physician visit: \$5-10 copay</p> <p>Specialist visit: \$50 copay</p> <p>Please refer to the Premium/Cost-Sharing Table to find out the premium/cost-sharing in your area.</p>

<p style="text-align: center;"><b>UPMC <i>for Life</i> HMO Rx (HMO)</b></p>	<p style="text-align: center;"><b>UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</b></p>
<p>Diabetes monitoring supplies: 20% of the cost</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.</p>	<p>Diabetes monitoring supplies: 20% of the cost</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.</p>
<p>Diagnostic radiology services (such as MRIs, CT scans): \$200 copay</p> <p>Diagnostic tests and procedures: \$0-5 copay, depending on the service</p> <p>Lab services: \$0-5 copay, depending on the service</p> <p>Outpatient x-rays: \$40 copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): \$25 copay</p>	<p>Diagnostic radiology services (such as MRIs, CT scans): \$75 copay</p> <p>Diagnostic tests and procedures: You pay nothing</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: \$20 copay</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing</p>
<p>Primary care physician visit: \$5 copay</p> <p>Specialist visit: \$40 copay</p>	<p>Primary care physician visit: \$5 copay</p> <p>Specialist visit: \$25 copay</p>

	<b>UPMC <i>for Life</i> HMO (HMO)</b>	<b>UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</b>
<b>Durable Medical Equipment</b> <i>(wheelchairs, oxygen, etc.)</i> <sup>1</sup>	20% of the cost	You pay nothing (after you pay your deductible)
<b>Emergency Care</b>	\$75 copay  If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.  Worldwide coverage	\$75 copay  If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.  Worldwide coverage
<b>Foot Care</b> <i>(podiatry services)</i>	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$45 copay  Routine foot care (for up to 4 visit(s) every year): \$45 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay  (after you pay your deductible)
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues: \$45 copay	Exam to diagnose and treat hearing and balance issues: \$50 copay
<b>Home Health Care</b> <sup>1</sup>	You pay nothing	You pay nothing (after you pay your deductible)

UPMC <i>for Life</i> HMO Rx (HMO)	UPMC <i>for Life</i> HMO Rx Enhanced (HMO)
20% of the cost	20% of the cost
<p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>Worldwide coverage</p>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>Worldwide coverage</p>
<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay</p> <p>Routine foot care (for up to 4 visit(s) every year): \$40 copay</p>	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$25 copay</p> <p>Routine foot care (for up to 4 visit(s) every year): \$25 copay</p>
<p>Exam to diagnose and treat hearing and balance issues: \$40 copay</p>	<p>Exam to diagnose and treat hearing and balance issues: \$25 copay</p> <p>Routine hearing exam (for up to 1 every year): \$25 copay</p> <p>Hearing aid fitting/evaluation (for up to 1 every three years): \$25 copay</p> <p>Hearing aid: \$0 copay</p> <p>Our plan pays up to \$1,500 every three years for hearing aids.</p>
You pay nothing	You pay nothing



	<b>UPMC <i>for Life</i> HMO (HMO)</b>	<b>UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</b>
<b>Mental Health Care<sup>1</sup></b>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$350 copay per stay</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$300 copay per stay</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay (after you pay your deductible)</p> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>
<b>Outpatient Rehabilitation</b>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$40 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: You pay nothing</p> <p>Physical therapy and speech and language therapy visit: You pay nothing (after you pay your deductible)</p>

<p align="center"><b>UPMC <i>for Life</i> HMO Rx (HMO)</b></p>	<p align="center"><b>UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</b></p>
<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$350 copay per stay</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>• \$125 copay per stay</li> </ul> <p>Outpatient group therapy visit: \$25 copay</p> <p>Outpatient individual therapy visit: \$25 copay</p> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>
<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$40 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$25 copay</p> <p>Physical therapy and speech and language therapy visit: \$25 copay</p>

	<b>UPMC for Life HMO (HMO)</b>	<b>UPMC for Life HMO Deductible with Rx (HMO)</b>
<b>Outpatient Substance Abuse</b>	Group therapy visit: \$40 copay  Individual therapy visit: \$40 copay	Group therapy visit: \$40 copay  Individual therapy visit: \$40 copay (after you pay your deductible)
<b>Outpatient Surgery<sup>1</sup></b>	Ambulatory surgical center: \$225 copay  Outpatient hospital: \$225 copay	Ambulatory surgical center: \$125 copay  Outpatient hospital: \$125 copay (after you pay your deductible)
<b>Over-the-Counter Items</b>	Not covered	Not covered
<b>Prosthetic Devices</b> <i>(braces, artificial limbs, etc.)</i>	Prosthetic devices: 20% of the cost  Related medical supplies: 20% of the cost	Prosthetic devices: You pay nothing  Related medical supplies: You pay nothing (after you pay your deductible)
<b>Renal Dialysis</b>	20% of the cost	20% of the cost (after you pay your deductible)
<b>Transportation</b>	Not covered	Not covered
<b>Urgently Needed Services</b>	\$50 copay	\$50 copay
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-45 copay, depending on the service  Routine eye exam (for up to 1 every two years): \$0 copay  Contact lenses (for up to 1 every two years): \$0 copay	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-50 copay, depending on the service  Routine eye exam (for up to 1 every two years): \$0 copay  Contact lenses (for up to 1 every two years): \$0 copay

UPMC <i>for Life</i> HMO Rx (HMO)	UPMC <i>for Life</i> HMO Rx Enhanced (HMO)
Group therapy visit: \$40 copay  Individual therapy visit: \$40 copay	Group therapy visit: \$25 copay  Individual therapy visit: \$25 copay
Ambulatory surgical center: \$250 copay  Outpatient hospital: \$250 copay	Ambulatory surgical center: \$80 copay  Outpatient hospital: \$80 copay
Not covered	Not covered
Prosthetic devices: 20% of the cost  Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost  Related medical supplies: 20% of the cost
20% of the cost	20% of the cost
Not covered	Not covered
\$50 copay	\$50 copay
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service  Routine eye exam (for up to 1 every two years): \$0 copay  Contact lenses (for up to 1 every two years): \$0 copay	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-25 copay, depending on the service  Routine eye exam (for up to 1 every year): \$0 copay  Contact lenses (for up to 1 every year): \$0 copay

	<b>UPMC for Life HMO (HMO)</b>	<b>UPMC for Life HMO Deductible with Rx (HMO)</b>
<b>Vision Services</b> <i>(continued)</i>	<p>Eyeglasses (frames and lenses) (for up to 1 every two years): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>	<p>Eyeglasses (frames and lenses) (for up to 1 every two years): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$150 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>
<b>Preventive Care</b>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> </ul>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> </ul>

<p align="center"><b>UPMC <i>for Life</i> HMO Rx (HMO)</b></p>	<p align="center"><b>UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</b></p>
<p>Eyeglasses (frames and lenses) (for up to 1 every two years): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$175 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>	<p>Eyeglasses (frames and lenses) (for up to 1 every year): \$0 copay</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$200 every year for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>
<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> </ul>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screenings</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings</li> <li>• HIV screening</li> <li>• Medical nutrition therapy services</li> <li>• Obesity screening and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screening and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> </ul>

	<b>UPMC <i>for Life</i> HMO (HMO)</b>	<b>UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</b>
<b>Preventive Care</b> <i>(continued)</i>	<ul style="list-style-type: none"> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Hospice</b>	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care<sup>1</sup></b>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>• \$350 copay per stay</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>• \$300 copay per stay</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul> <p>(after you pay your deductible)</p> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>
<b>Inpatient Mental Health Care</b>	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>• \$40 copay per day for days 1 through 20</li> <li>• \$80 copay per day for days 21 through 100</li> </ul>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>• You pay nothing per day for days 1 through 20</li> <li>• \$160 copay per day for days 21 through 100</li> </ul>



<p style="text-align: center;"><b>UPMC <i>for Life</i> HMO Rx (HMO)</b></p>	<p style="text-align: center;"><b>UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</b></p>
<ul style="list-style-type: none"> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> <li>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> <li>• Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>
<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>• \$350 copay per stay</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>• \$125 copay per stay</li> <li>• You pay nothing per day for days 91 and beyond</li> </ul> <p>Inpatient benefits are annual and not defined or applied as benefit periods in Original Medicare.</p>
<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p>	<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p>
<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>• \$40 copay per day for days 1 through 20</li> <li>• \$80 copay per day for days 21 through 100</li> </ul>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>• \$10 copay per day for days 1 through 20</li> <li>• \$60 copay per day for days 21 through 100</li> </ul>

	<b>UPMC <i>for Life</i> (HMO)</b>	<b>UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</b>
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**PRESCRIPTION DRUG BENEFITS**

<b>How much do I pay?</b>	<p>For Part B drugs such as chemotherapy drugs<sup>1</sup>: 20% of the cost</p> <p>Other Part B drugs<sup>1</sup>: 20% of the cost</p> <p>Our plan does not cover Part D prescription drug.</p>	<p>For Part B drugs such as chemotherapy drugs<sup>1</sup>: 20% of the cost</p> <p>Other Part B drugs<sup>1</sup>: 20% of the cost</p>
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<b>Initial Coverage</b>		<p>You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p><b>Standard Retail Cost-Sharing</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Tier</th> <th style="text-align: center;">One-month supply</th> <th style="text-align: center;">Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Generic)</td> <td style="text-align: center;">\$14 copay</td> <td style="text-align: center;">\$42 copay</td> </tr> <tr> <td>Tier 2 (Preferred Brand)</td> <td style="text-align: center;">\$47 copay</td> <td style="text-align: center;">\$141 copay</td> </tr> <tr> <td>Tier 3 (Non-Preferred Brand)</td> <td style="text-align: center;">\$100 copay</td> <td style="text-align: center;">\$300 copay</td> </tr> <tr> <td>Tier 4 (Specialty Tier)</td> <td style="text-align: center;">33% of the cost</td> <td style="text-align: center;">Not Offered</td> </tr> <tr> <td>Tier 5 (Select Care Drugs)</td> <td style="text-align: center;">\$0</td> <td style="text-align: center;">\$0</td> </tr> </tbody> </table>	Tier	One-month supply	Three-month supply	Tier 1 (Generic)	\$14 copay	\$42 copay	Tier 2 (Preferred Brand)	\$47 copay	\$141 copay	Tier 3 (Non-Preferred Brand)	\$100 copay	\$300 copay	Tier 4 (Specialty Tier)	33% of the cost	Not Offered	Tier 5 (Select Care Drugs)	\$0	\$0
Tier	One-month supply	Three-month supply																		
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**UPMC for Life  
HMO Rx (HMO)**

**UPMC for Life  
HMO Rx Enhanced (HMO)**

For Part B drugs such as chemotherapy drugs<sup>1</sup>:  
20% of the cost

Other Part B drugs<sup>1</sup>:  
20% of the cost

For Part B drugs such as chemotherapy drugs<sup>1</sup>:  
20% of the cost

Other Part B drugs<sup>1</sup>:  
20% of the cost

You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

**Standard Retail Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Three-month supply</b>
Tier 1 (Generic)	\$12 copay	\$36 copay
Tier 2 (Preferred Brand)	\$47 copay	\$141 copay
Tier 3 (Non-Preferred Brand)	\$100 copay	\$300 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	\$0	\$0

You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

**Standard Retail Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Three-month supply</b>
Tier 1 (Generic)	\$12 copay	\$36 copay
Tier 2 (Preferred Brand)	\$47 copay	\$141 copay
Tier 3 (Non-Preferred Brand)	\$100 copay	\$300 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	\$0	\$0

	UPMC <i>for Life</i> HMO (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)																		
<b>Initial Coverage</b> <i>(continued)</i>		<p><b>Standard Mail Order Cost-Sharing</b></p> <table border="1" data-bbox="971 342 1455 1062"> <thead> <tr> <th data-bbox="971 342 1162 470"><b>Tier</b></th> <th data-bbox="1162 342 1308 470"><b>One-month supply</b></th> <th data-bbox="1308 342 1455 470"><b>Three-month supply</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="971 470 1162 569">Tier 1 (Generic)</td> <td data-bbox="1162 470 1308 569">Not Offered</td> <td data-bbox="1308 470 1455 569">\$28 copay</td> </tr> <tr> <td data-bbox="971 569 1162 682">Tier 2 (Preferred Brand)</td> <td data-bbox="1162 569 1308 682">Not Offered</td> <td data-bbox="1308 569 1455 682">\$117.50 copay</td> </tr> <tr> <td data-bbox="971 682 1162 831">Tier 3 (Non-Preferred Brand)</td> <td data-bbox="1162 682 1308 831">Not Offered</td> <td data-bbox="1308 682 1455 831">\$300 copay</td> </tr> <tr> <td data-bbox="971 831 1162 945">Tier 4 (Specialty Tier)</td> <td data-bbox="1162 831 1308 945">33% of the cost</td> <td data-bbox="1308 831 1455 945">Not Offered</td> </tr> <tr> <td data-bbox="971 945 1162 1062">Tier 5 (Select Care Drugs)</td> <td data-bbox="1162 945 1308 1062">Not Offered</td> <td data-bbox="1308 945 1455 1062">\$0</td> </tr> </tbody> </table> <p data-bbox="958 1098 1451 1205">If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p data-bbox="958 1241 1451 1383">You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>	<b>Tier</b>	<b>One-month supply</b>	<b>Three-month supply</b>	Tier 1 (Generic)	Not Offered	\$28 copay	Tier 2 (Preferred Brand)	Not Offered	\$117.50 copay	Tier 3 (Non-Preferred Brand)	Not Offered	\$300 copay	Tier 4 (Specialty Tier)	33% of the cost	Not Offered	Tier 5 (Select Care Drugs)	Not Offered	\$0
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Tier 5 (Select Care Drugs)	Not Offered	\$0																		

**UPMC for Life  
HMO Rx (HMO)**

**Standard Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Three-month supply</b>
Tier 1 (Generic)	Not Offered	\$24 copay
Tier 2 (Preferred Brand)	Not Offered	\$117.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	\$300 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	Not Offered	\$0

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

**UPMC for Life  
HMO Rx Enhanced (HMO)**

**Standard Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Three-month supply</b>
Tier 1 (Generic)	Not Offered	\$24 copay
Tier 2 (Preferred Brand)	Not Offered	\$117.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	\$300 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	Not Offered	\$0

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

	UPMC <i>for Life</i> HMO (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
<b>Coverage Gap</b>		<p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>
<b>Catastrophic Coverage</b>		<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% of the cost, or</li> <li>• \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>

**UPMC *for Life*  
HMO Rx (HMO)**

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:

- 5% of the cost, or
- \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.

**UPMC *for Life*  
HMO Rx Enhanced (HMO)**

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:

- 5% of the cost, or
- \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.



## PREMIUM/COST-SHARING TABLE

The tables below show the monthly plan premium amounts and primary care physician visit cost-sharing for **UPMC *for Life* HMO Deductible with Rx (HMO)** for our two regions. If you have any questions about your plan premium or benefit cost-sharing, please contact UPMC *for Life* Member Services at 1-877-539-3080. TTY users should call 1-800-361-2629.

The service area for **UPMC *for Life* HMO Deductible with Rx (HMO)** in the Western Pennsylvania region includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland

The service area for **UPMC *for Life* HMO Deductible with Rx (HMO)** in the Lancaster region includes the following county in Pennsylvania: Lancaster

Plan	Premium	
	Western Pennsylvania	Lancaster
UPMC <i>for Life</i> HMO Deductible with Rx (HMO)	\$22	\$0

Plan	Primary Care Physician Cost-Sharing	
	Western Pennsylvania	Lancaster
UPMC <i>for Life</i> HMO Deductible with Rx (HMO)	\$5 copay	\$10 copay

## **Additional Information About UPMC *for Life* HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO)**

With UPMC *for Life* HMO, HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO) you also receive the following supplemental benefits:

- Annual Physical Exam – UPMC *for Life* members are eligible for an annual routine physical exam that provides additional evaluations not performed in the Annual Wellness Visit.
- Fitness Membership – UPMC *for Life* provides a fitness center basic membership through its Silver&Fit<sup>®</sup> fitness facility network. UPMC *for Life* members can also choose to participate at home with DVDs such as a walking kit, exercise kit, or yoga.
- Nurse Advice Line – UPMC *for Life* offers a 24/7 nurse advice line available at 1-866-918-1591. TTY users call 1-866-918-1593. UPMC *for Life* members can call to obtain advice from a nurse regarding symptoms or medical conditions they may be experiencing.
- Remote Access Technology – UPMC *for Life* provides members with telehealth access using a computer or similar system device. UPMC *for Life* members can create an account to complete medical questionnaires about their symptoms and receive a diagnosis and plan of care.

