UPMC *for Life* HMO Deductible with Rx (HMO) offered by UPMC Health Plan

Annual Notice of Changes for 2016

You are currently enrolled as a member of UPMC *for Life* HMO Deductible with Rx. Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes*.

- **You have from October 15 until December 7, to make changes to your Medicare coverage for next year.**

Additional Resources

- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 6.1 of this booklet).
- This document may be available in an alternative format such as Braille, large print, or audio.

About UPMC *for Life* HMO Deductible with Rx

- 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 Network Inc., and UPMC Health Benefits Inc.
- When this booklet says "we," "us," or "our," it means UPMC Health Plan. When it says "plan" or "our plan," it means UPMC *for Life* HMO Deductible with Rx.

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Think About Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our Provider Directory.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to stay with UPMC *for Life* HMO Deductible with Rx:

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2016. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for UPMC *for Life* HMO Deductible with Rx in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	• $18	• $22
Deductible	• $750	• $750
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	• $4,000	• $4,000
Doctor office visits	**Primary care visits:** • $5 copay per visit **Specialist visits:** • $50 copay per visit	**Primary care visits:** • $5 copay per visit **Specialist visits:** • $50 copay per visit

Cost	2015 (this year)	2016 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	• $200 copay per stay for inpatient hospital and inpatient mental health care (after deductible)	• $300 copay per stay for inpatient hospital and inpatient mental health care (after deductible)
Part D prescription drug coverage (See Section 1.6 for details.)	**Deductible: $0** **Copayment/Coinsurance during the Initial Coverage Stage:** • Drug Tier 1: $10 copay for a 30-day supply • Drug Tier 2: $45 copay for a 30-day supply • Drug Tier 3: $95 copay for a 30-day supply • Drug Tier 4: 33% coinsurance for a 30-day supply • Drug Tier 5: $0 copay for a 30-day supply	**Deductible: $0** **Copayment/Coinsurance during the Initial Coverage Stage:** • Drug Tier 1: $14 copay for a 30-day supply • Drug Tier 2: $47 copay for a 30-day supply • Drug Tier 3: $100 copay for a 30-day supply • Drug Tier 4: 33% coinsurance for a 30-day supply • Drug Tier 5: $0 copay for a 30-day supply

Annual Notice of Changes for 2016

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$18**	**$22**

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2015 (this year)	2016 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,000	$4,000 • Once you have paid $4,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year.

An updated Provider Directory is located on our website at https://www.upmchealthplan.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2016 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year.

An updated Pharmacy Directory is located on our website at https://www.upmchealthplan.com/medicare/documents-and-forms/. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2016 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2016 Evidence of Coverage.*

Cost	2015 (this year)	2016 (next year)
Inpatient Hospital and Inpatient Mental Health Care	• You pay a $200 copay per for inpatient hospital and inpatient mental health care stay (after deductible).	• You pay a $300 copay per stay for inpatient hospital and inpatient mental health care (after deductible).
Skilled Nursing Facility (SNF)	• You pay a $125 copay per day for days 21-100.	• You pay a $160 copay per day for days 21-100.
Podiatry Services	• You pay a $50 copay for each podiatry service.	• You pay a $50 copay for each podiatry service (after deductible).

Cost	2015 (this year)	2016 (next year)
Outpatient Mental Health	• You pay a $40 copay for each outpatient mental health visit.	• You pay a $40 copay for each outpatient mental health visit (after deductible).
Outpatient Psychiatric Services	• You pay a $40 copay for each outpatient psychiatric service.	• You pay a $40 copay for each outpatient psychiatric service (after deductible).
Outpatient Substance Abuse	• You pay a $40 copay for each outpatient substance abuse visit.	• You pay a $40 copay for each outpatient substance abuse visit (after deductible).
Ambulance Services	• You pay a $0 copay per one-way trip (after deductible).	• You pay a $100 copay per one-way trip (after deductible).
Emergency Care	• You pay a $65 copay for each emergency care visit.	• You pay a $75 copay for each emergency care visit.
Diabetic Supplies	• You pay 10% coinsurance for diabetic supplies (after deductible).	• You pay 20% coinsurance for diabetic supplies (after deductible).

Cost	2015 (this year)	2016 (next year)
Diabetic Shoes or Inserts	• You pay 10% coinsurance per pair of diabetic shoes or inserts (after deductible).	• You pay 20% coinsurance per pair for diabetic shoes or inserts (after deductible).
Kidney Disease Renal Dialysis (ESRD)	• You pay 20% coinsurance for kidney disease renal dialysis.	• You pay 20% coinsurance for kidney disease renal dialysis (after deductible).
Lab Services and Diagnostic Procedures/Tests	• You pay a $0-$5 copay per day for lab services and diagnostic procedures/tests.	• You pay a $0-$10 copay per day for lab services and diagnostic procedures/tests.
Diagnostic Radiological Services (Advanced Imaging)	• You pay a $50 copay for each diagnostic radiological service (Advanced imaging) (after deductible).	• You pay a $100 copay for each diagnostic radiological service (Advanced imaging) (after deductible).
Routine Dental Bitewing X-rays	• You pay a $15 copay for routine dental bitewing x-rays once every 3 years.	• You pay a $15 copay for routine dental bitewing x-rays once every year.
Remote Technologies	• Remote technologies are <u>not</u> covered.	• You pay a $5 copay for each eVisit service. • You Pay a $38 copay for each eDerm service.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. The Drug List we included in this envelope includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our Web site (https://www.upmchealthplan.com/medicare/documents-and-forms/).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

In most instances, if you or your provider received approval for a formulary exception for a prescription drug that is not on our current 2016 formulary, the exception approval will continue to be covered in 2016. However, if your original exception approval letter had a specific timeframe for coverage of the prescription drug that timeframe will still apply (e.g., covered for 3 months), it will not start over in 2016.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which

tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2015 (this year)	2016 (next year)
Stage 1: Yearly Deductible Stage	• Because we have no deductible, this payment stage does not apply to you.	• Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage*.

Stage	2015 (this year)	2016 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:** **Generic Drugs Tier 1:** • You pay $10 per prescription. **Preferred Brand Drugs Tier 2:** • You pay $45 per prescription. **Non-Preferred Brand Drugs Tier 3:** • You pay $95 per prescription. **Specialty Drugs Tier 4:** • You pay 33% of the total cost. **Select Care Drugs Tier 5:** • You pay $0 per prescription. Once your total drug costs have reached $2,960, you will move to the next stage (the Coverage Gap Stage).	**Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:** **Generic Drugs Tier 1:** • You pay $14 per prescription. **Preferred Brand Drugs Tier 2:** • You pay $47 per prescription. **Non-Preferred Brand Drugs Tier 3:** • You pay $100 per prescription. **Specialty Drugs Tier 4:** • You pay 33% of the total cost. **Select Care Drugs Tier 5:** • You pay $0 per prescription. Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in UPMC *for Life* HMO Deductible with Rx

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2016.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2016 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, UPMC Health Plan offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from UPMC *for Life* HMO Deductible with Rx.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from UPMC *for Life* HMO Deductible with Rx.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2016.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2016, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling About Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. APPRISE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (www.aging.state.pa.us).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
      or
    - Your State Medicaid Office (applications);
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called PACE/PACENET that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).

SECTION 6 Questions?

Section 6.1 – Getting Help from UPMC *for Life* HMO Deductible with Rx

Questions? We're here to help. Please call Member Services at 1-877-539-3080. (TTY only, call 1-800-361-2629). We are available for phone calls October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m. Calls to these numbers are free.

Read your 2016 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2016. For details, look in the 2016 *Evidence of Coverage* for UPMC *for Life* HMO Deductible with Rx. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at https://www.upmchealthplan.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov).. It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to (http://www.medicare.gov) and click on "Find health & drug plans").

Read *Medicare & You 2016*

You can read the *Medicare & You 2016* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov). or 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.