[UPMC Health Plan]

[UPMC Health Options Inc.]
Application for Health Insurance

Thank you for applying for coverage from UPMC Health Plan. Until you receive an acceptance letter from UPMC Health Plan, it is important that you do not cancel any other coverage. If accepted by UPMC Health Plan, you will receive an acceptance letter with the policy effective date. **Canceling your existing coverage before your new policy goes into effect will result in your being uninsured for that time period.**

When completing this application:

- You must provide the home address, telephone number, and Social Security number for all applicants.
- You must provide your complete home address.
- You must complete all questions on this form.
- You must select an effective date.
- You must sign the application.

Without this information, UPMC Health Plan will not be able to process your application.

Easy steps to apply:

- In black ink carefully complete pages 2 through 12, in order.
- If you are not working with an insurance agent/producer, please return the completed application to the following address:
  [ATTN: Sales, UPMC Health Plan
  U.S. Steel Tower
  600 Grant Street
  Floor 25
  Pittsburgh, PA 15219]
- Please retain a copy of this completed application.

UPMC *Advantage*

[UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., and/or UPMC Health Plan Inc.]

UPMC HP Application

Eligibility status

Please check the box that applies to you.

☐ Are you applying during the annual Open Enrollment Period? **If yes, choose an effective date at the bottom of this page. Then turn to page 3.**
☐ Are you applying because of a qualifying life event? **If yes, complete the rest of this section.**

Typically, you may enroll in a [UPMC *Advantage]* plan only during the annual Open Enrollment Period, [November 1, 2016, through January 31, 2017.] However, some situations may qualify you to enroll in a plan outside this period.

Please read the following statements carefully and check the box that applies to you. When you check a box, you are certifying that, to the best of your knowledge, you are eligible for an exception to the standard Open Enrollment Period. If we later determine that the information you provided is incorrect, you could be disenrolled from this plan.

[Qualifying Life Event
Did you or anyone in your household lose health coverage in the **last 60 days,** OR do you expect to lose it in the **next 60 days?** (Voluntarily giving up coverage or losing coverage because of failure to pay premiums does not qualify you for special enrollment.)

☐ Yes ☐ No

Have any of these qualifying life events happened to you during the past 60 days?

Gained a dependent due to birth.	☐ Yes ☐ No
Gained a dependent due to adoption or foster care.	☐ Yes ☐ No
Gained a dependent due to marriage.	☐ Yes ☐ No
Lost a dependent due to death.	☐ Yes ☐ No
Lost a dependent due to divorce.	☐ Yes ☐ No
Permanently moved into UPMC Health Plan's service area.	☐ Yes ☐ No
Received a court order that affects insurance coverage. This may be, for example, a divorce decree or custody order.	☐ Yes ☐ No
Had a change in income that affects your eligibility for premium tax credits or cost-sharing reductions. (For people already enrolled in federal Health Insurance Marketplace coverage, this affects eligibility for premium tax credits or cost-sharing reductions.)	☐ Yes ☐ No
Gained citizenship or lawful presence in the United States.	☐ Yes ☐ No
Released from incarceration.	☐ Yes ☐ No
Lost or will lose in the next 60 days minimum essential coverage due to aging off a parent's coverage at 26 or losing eligibility for Medicaid, CHIP, etc.	☐ Yes ☐ No
Gained status in a federally recognized tribe or Alaska Native Claims Settlement Act Corp.	☐ Yes ☐ No

If you do not see your applicable qualifying event above and you are unsure if you are eligible, please contact the federal Health Insurance Marketplace at 1-800-318-2596.

You have 60 calendar days from these events to enroll in a new plan. You will be required to provide supporting documentation to prove eligibility. This application will not be considered complete and will not be processed unless acceptable documentation is provided to UPMC Health Plan within 60 days of your qualifying event.]

Date of qualifying event _____

Requested effective date _____

[**How to determine your effective date:** If you accept coverage between the first and the last day of the month, you may select an effective date of the first day of the following month or the first day of the second following month. For example, if you accept on January 15, your coverage may be effective on February 1 or March 1. If you enroll through the Federally Facilitated Marketplace (FFM), your effective date is determined by the FFM.]

[**Special cases:** Newborn and newly adopted children are covered effective on the date of their birth or adoption. If you marry or if you lose minimum essential coverage, your coverage is effective on the first day of the month **after** the month in which you have accepted coverage. For example, if you accept coverage in January, your coverage will be effective February 1.]

Applicant information

[Name (Last, First, Middle Initial)	Marital Status	Social Security Number	Date of Birth	Age	Sex (M/F)
Primary Applicant:	☐ Married ☐ Single				
Parent/Guardian (if Primary Applicant is under 19):					
Spouse/Domestic Partner:					
Dependent Children Under 26					
a.					
b.					
c.					
d.					
e.					]

[Tobacco Use

Tobacco use means that a person currently uses or has used tobacco an average of four or more times a week within the past six months. Tobacco includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by Native American Indians and Alaskans) are specifically exempt. **Do you or any dependents over the age of 18 use tobacco? If yes, please provide the following information.**

Name of Tobacco User	Date of Last Use	Would this tobacco user like to enroll in a tobacco cessation program with UPMC Health Plan?* Answer Yes or No.

*If you answer yes and you become a UPMC Health Plan member, a health coach may contact you to discuss our tobacco cessation program. You may also enroll by calling us at 1-800-807-0751 after your effective date.]

[Primary Applicant's Home Address (PO boxes are not accepted)		
Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:
Email Address:		
Primary Applicant's Mailing Address ☐ Same as Home Address		
Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:
☐ By checking this box, if you become a UPMC Health Plan member, you agree to receive initial plan documents **by accessing our member website.** (This includes your policy, schedules of benefits, and other important information about where you can access services.)		
☐ By checking this box, you agree to receive electronic marketing communications from UPMC Health Plan and its business units or affiliates. If you do not wish to receive these communications, you may opt out by using the unsubscribe feature in the email after you receive it.		
Spouse, Domestic Partner, or Dependent's Address (if living elsewhere)		
Name of Spouse, Domestic Partner, or Dependent:		
Street Address:		
City:	State:	ZIP Code:
PO boxes are not accepted.		
Primary Applicant's Phone Number		
Home:		
Other:		
Mobile:]		

Plan selection

[**Instructions:** On the next two pages, you will choose your network and medical plan. When you make your selection, it is important to consider the level of coverage you need, your budget, where you live, and if your provider is in the network.]

[1. Choose one network

UPMC Health Plan offers multiple network options. The network refers to where you have access to participating providers and hospitals for routine care. Participating providers in each network vary. Make one selection for your network. You must choose a network that is offered in the county where you live.

UPMC Partner Network

☐ **Network offered to individuals living in these counties:**

Allegheny	Blair	Lawrence	Venango
Bedford	Erie	Mercer	

Plans in this network give you access to care from UPMC-owned facilities and providers located in all counties in western Pennsylvania. See below for specific counties.*

UPMC Select Network

☐ **Network offered to individuals living in these counties:**

Allegheny	Washington
Beaver	Westmoreland
Butler	

Plans in this network include all UPMC providers and UPMC-owned facilities, plus our community partners, Butler Memorial Hospital, Excela Health System, Heritage Valley Health System, Monongahela Valley Hospital, and Washington Physician Hospital Organization.

UPMC Premium Network

☐ **Network offered to individuals living in these counties:**

Allegheny	Clearfield	Lawrence
Armstrong	Crawford	McKean
Beaver	Elk	Mercer
Bedford	Erie	Potter
Blair	Fayette	Somerset
Butler	Forest	Venango
Cambria	Greene	Warren
Cameron	Huntingdon	Washington
Centre	Indiana	Westmoreland
Clarion	Jefferson	

Plans in this network give you access to care from participating providers located in all counties in western Pennsylvania, including Centre County. See below for specific counties in addition to Centre County.*

To find out if your doctor or specialist is part of the UPMC Health Plan network, visit www.upmchealthplan.com/find, call 1-877-563-0292, or contact your provider.]

*[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,] [Westmoreland]

[2. Choose one plan

Make one selection for your medical plan. The cost of your coverage will be influenced by deductibles, coinsurance, copayments, and out-of-pocket maximums. All medical plans include Essential Health Benefits coverage for pediatric dental and vision. Optional adult dental coverage is available.

Choose one plan	Deductible Amount	
	Individual	**Family**
Bronze		
☐ UPMC *Advantage* Bronze $6,950/$35	$6,950	$13,900
Silver		
☐ UPMC *Advantage* Silver $3,250/$10	$3,250	$6,500
☐ UPMC *Advantage* Silver HSA $2,600/20%*	$2,600	$5,200
☐ UPMC *Advantage* Silver $1,750/$30	$1,750	$3,500
☐ UPMC *Advantage* Silver $0/$50	$0	$0
☐ UPMC *Advantage* Silver $3,500/$30	$3,500	$7,000
Gold		
☐ UPMC *Advantage* Gold $750/$10	$750	$1,500
Platinum		
☐ UPMC *Advantage* Platinum $250/$20	$250	$500
†Catastrophic		
☐ UPMC *Advantage* Catastrophic $7,150/0%	$7,150	$14,300

*If you choose to enroll in the UPMC *Advantage* Silver HSA $2,600/20% plan, you may be eligible to open a health savings account (HSA) and begin saving money for health care expenses. Would you like to be contacted by UPMC Health Plan's HSA partner to learn more about how to open a health savings account? *(Please note, if you are claimed as a dependent on someone else's tax return, you will not be eligible to open an HSA.)*

☐ **Yes** ☐ **No**

†Catastrophic plans are offered to eligible individuals under 30 living throughout western Pennsylvania. If choosing this plan, you must select the Full PPO network option in the previous section. People 30 and older with a "hardship exemption" may buy a catastrophic plan. Financial hardship exemptions are determined by the Federally Facilitated Marketplace.

If you have questions or want to learn more about each plan, visit www.upmchealthplan.com/coverage, call 1-877-563-0292, or contact your producer/insurance agent.]

[3. Dental coverage

UPMC Health Plan adult dental coverage is administered by Dominion Dental Inc. Adult dental coverage is optional. If multiple family members apply for coverage on this application, only one dental plan option can be chosen. Coverage applies to all family members on the application who are age 19 and older. Please refer to the Dominion Dental Services policies for more information.

(Access PPO Plan Policy, Form# PA15PICOC; $30 Preventive Plan Policy, Form# PA 15UPMC-COC-2).

To find out if a dentist participates in the Dominion Dental network, please visit www.DominionDental.com/upmcdentists and select your desired dental plan in the Plan dropdown menu.

Dental coverage must be paired with a medical plan and be added only during open enrollment and renewal.

Choose a Dominion Dental Services plan:

☐ $30 Preventive Plan

- Fixed member copayment of $30 per general dentist office visit when diagnostic and preventive services are performed. Members must receive services from a participating network dentist.

☐ Access PPO Plan

- Twice-a-year preventive services, including routine exams, cleaning, and bitewing x-rays. $50 per insured person ($150 family) deductible applies to all services. Member may receive services from any licensed dentist.]

Payment election

[You must choose one of the payment methods below to make your first monthly payment. Once you are enrolled and you receive your first invoice, you can log in to *My*Health OnLine to enroll in autopay for your future monthly premium payments.

Card or Account Information:		
Name on Account:		
Billing Address:		
City:	State:	ZIP Code:
Country:		

Select Card Type:	
☐ [Visa] ☐ [MasterCard] ☐ [American Express] ☐ [Discover]	Card Number: Expiration Date (MM/YY):

Or

Select Account Type:	
☐ Checking Account ☐ Savings Account	ABA Routing Number: Account Number:]

Statement of understanding

Review the completed application and read the section below carefully before signing.

I have read this application or had it read to me. I represent that the answers and statements on this application are true, complete, and correctly recorded. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand and agree that: (1) this application and the payment of the initial premium do not give me immediate coverage; (2) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (3) this completed application, and any supplements or amendments, will be made a part of any policy or certificate which may be issued; (4) the insurance producer may not change or waive any right or requirement, and is authorized to submit the application, to submit the initial premium or payment information, and to receive acceptance/denial information; and (5) providing false information or omitting relevant information in this application may result in the denial of claims or cancellation of coverage.

A request for new insurance coverage will require me to submit a completed application. I understand that my application will be void after 60 days if it has not been completed and submitted for review.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan, as explained in UPMC Health Plan's Notice of Privacy Practices. UPMC Health Plan may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I understand I have the right to retain a copy of this authorization. UPMC Health Plan's Notice of Privacy Practices may be reviewed at www.upmchealthplan.com or requested from Member Services at 1-855-489-3494.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Do you have current insurance coverage this policy will replace? ☐ Yes ☐ No

If yes, please read this section and mark the checkbox below.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by UPMC Health Plan.* Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied.

[Please note: if you have current coverage with UPMC Health Plan, it will not automatically terminate upon submission of this application for coverage. You must contact UPMC Health Plan separately to terminate your current coverage.]

☐ **I have read and completely understand the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.**

Payment Election Terms and Conditions

[I hereby authorize UPMC Health Plan, its affiliates, and its subsidiaries to deduct insurance payments from my account at the financial institution named herein. The information herein is for the first month's premium payment. By providing payment information and submitting the application, I accept the rate for this plan. Online payments are subject to the terms and conditions of the online payment system, which can be found at [www.xxxxxxxxxxxx].

Timing of Payments

One-Time Payment

Payments made by deduction from your bank account will be withdrawn from your bank account within three business days. Business days are Monday through Friday, except for banking holidays.

Payments made by credit card will be charged to your card on the day the payment is made.

You are solely responsible for making payments prior to the due date, and you are solely responsible for any late fees charged by UPMC Health Plan for payments not made by the due date.

Your Account

Should you choose to pay by deduction from your bank account, it is your responsibility to ensure that there are sufficient funds in your bank account to cover the payment. If there is not enough money in your account, UPMC Health Plan will charge you a fee of $20, in addition to any interest that you would otherwise owe UPMC Health Plan if the payment was late. You are also solely responsible for paying any fees and/or interest charged by your financial institution.

You are responsible for paying all reasonable collection charges and costs, including attorney's fees and expenses of collection, if your payment is dishonored, refused, or not paid on time.

You should print a copy of this authorization/receipt for your records. You should also check your bank account statement or credit card statement to verify that the amounts deducted from your account are correct. The payments made will appear on your statement as charges from UPMC HP Portal Online.

Cancellation

Once you submit a one-time payment, the payment cannot be cancelled.

Unauthorized or Disputed Payments

If you believe that someone has made an unauthorized payment through the website, you should contact your financial institution immediately. You are solely responsible for any unauthorized payments, although your financial institution may provide fraud protection.

In case of disputes or questions about your bill or payments that you have made, please contact UPMC Health Plan by email at pb@upmc.edu or by phone at 1-855-489-3494. Customer Service is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

After you have completed the application and before you sign it, review it carefully to be certain that all information has been properly recorded.

[*UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., and/or UPMC Health Plan Inc.]

Your signature below completes your application and indicates your agreement with the checkboxes you marked in this application. By signing below, you acknowledge and agree that you are signing on behalf of yourself and all dependents included in this application and agree that the information you have provided on behalf of yourself and your dependents is true and correct to the best of your knowledge and belief.

☐ **I have read and completely understand the Statement of Understanding.**

☐ **I have read and completely understand the Payment Election Terms and Conditions.**

Signature of Primary Applicant

Signature of Parent/Guardian (if primary applicant is a minor) Relationship

Insurance producer statement

If you worked with a producer to complete this application, please ask the producer to complete this section.

Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has read the completed application, or it has been read to him or her. The applicant is fully aware that any false statement or misrepresentation may result in voidance of coverage under the policy.

Signature of Insurance Producer: _____

Print Full Name: _____

Optional

The information gathered in this optional section will be used in a collaborative manner, with the focus on you, to help UPMC Health Plan provide the highest quality plan of care to you and your family. Our goal is to work together to improve your overall health. **This information will not be used to set premium rates or determine eligibility for coverage.**

[Who was your previous insurance carrier?

☐ Aetna

☐ Cigna

☐ HealthAmerica

☐ Highmark

☐ UPMC

Policyholder Name:_____

Member ID Number: _____

☐ Other _____]

[Healthy Texts on the Go

Are you trying to create a new healthy habit? Or support your work with a health coach? A daily or weekly text message offering support, advice, and tips can be just the reminder you need to stay on track.

To sign up for this FREE service from UPMC Health Plan:

- Choose a topic that interests you (you can select more than one) and text the corresponding keyword to 876247.
    - Eat better: eatright
    - Manage stress: relax
    - Manage weight: lose
    - Be more active: befit
    - Stop smoking: quit
    - Manage diabetes: regulate
- You'll get a response asking if you'd like to receive daily or weekly texts.
- Text back "1" or "STOP" at any time if you want to stop receiving texts.
- To contact a health coach, call 1-800-807-0751.

Note: Although UPMC Health Plan does not charge for the text messages, data and message rates from your carrier may apply.]

[I authorize on behalf of myself and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information to evaluate and manage care. This information cannot and will not be used to medically underwrite, set premium rates, or determine coverage eligibility. This information will be used by UPMC Insurance Services Division for all lawful purposes including, but not limited to, medical management and implementation of health/wellness initiatives.]

Any health care provider, pharmacy benefit manager, or pharmacy-related service organization having any health information about my family or me is authorized to give it to UPMC Health Plan.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

This authorization shall remain valid for 30 months from the date of signature on this application. I (we) understand the following:

- A photocopy of this authorization is as valid as the original.
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan.
- I (we) may request revocation of this authorization as described in UPMC Health Plan's Notice of Privacy Practices.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.
- UPMC Health Plan cannot condition purchase of its health plan or eligibility for benefits on my (our) refusal to sign this authorization.
- I understand I have the right to retain a copy of this authorization.

Signature of Primary Applicant:_____]

Signature of Parent/Guardian
(if Primary Applicant is a minor): _____
Date Relationship

Translation Services

If you, or someone you're helping, has questions about UPMC Health Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-563-0292.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de UPMC Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-489-3494.

如果您，或是您正在協助的對象，有關於 插入 SBM 項目的名稱 UPMC Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-855-489-3494。

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về UPMC Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-489-3494.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводуUPMC Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-489-3494.

"Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut UPMC Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-855-489-3494 uffrufe.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 UPMC Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-489-3494 로 전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su UPMC Health Plan hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-489-3494.

علــى الحصـــول فـــي الحـق فلــــديك ، UPMC Health Plan بخصـــوص أســـئلة تســـاعده شــخص لـدى أو لـــديك كـان إن
والمعلومـــات المســـاعدة
1-855-489-3494. ب اتصـــل مـترجم مع للتحـــدث .تكلفــــة ايـة دون من بلغتـــك الضــــرورية

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de UPMC Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-489-3494.

Falls Sie oder jemand, dem Sie helfen, Fragen zum UPMC Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-489-3494 an.

જો તમે અથવા તમે કોઇને મદદ કરી રહ્◌ા◌ં તેમ ◌ાં◌થી કોઇને UPMC Health Plan વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ◌િ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ◌ા◌ં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્◌ો ◌િ ત કરિ મ ટે,આ 1-855-489-3494 પર કોલ કરો.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie UPMC Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-489-3494.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan UPMC Health Plan se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-855-489-3494.

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី UPMC Health Plan ហើ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន បៅកនុងភាសា ររស់អ្នក បោយមិនអ្ស់ប្រាក់ ។

បែើម្បីនិយាយជាមួយអ្នករកដប្រ សូម 1-855-489-3494 ។

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o UPMC Health Plan, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-489-3494.

[UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com]

2017 ON EXCHANGE APP 16PI0031 (MJA) 4/12/16