

2015 Summary of Benefits

HMO
Western Pennsylvania
H3907

**UPMC *for Life* HMO, HMO Deductible with Rx,
HMO Rx, and HMO Rx Enhanced (HMO)**

(a Medicare Advantage Health Maintenance Organization (HMO) offered by UPMC Health Plan, Inc. with a Medicare contract)

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

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

Who can join?

To join **UPMC *for Life* HMO, HMO Deductible with Rx, 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 and pharmacy directory at our website (www.upmchealthplan.com/medicare).

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.

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

UPMC for Life HMO Deductible with Rx, HMO Rx, and HMO Rx Enhanced (HMO) cover Part D drugs. 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, www.upmchealthplan.com/medicare/partd.html.

Or call us and we will send you a copy of the formulary.

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.

If you have any questions about this plan's benefits or costs, please contact
UPMC Health Plan for details.

Section II – Summary of Benefits

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	<ul style="list-style-type: none"> \$0 per month. In addition, you must keep paying your Medicare Part B premium. 	<ul style="list-style-type: none"> \$18 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	<ul style="list-style-type: none"> This plan does not have a deductible. 	<ul style="list-style-type: none"> This plan has deductibles for some hospital and medical services. \$750 per year for in-network services. This plan does not have a deductible for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	<ul style="list-style-type: none"> 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. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$3,400 for services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums. 	<ul style="list-style-type: none"> 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. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$4,000 for services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

UPMC <i>for Life</i> HMO Rx (HMO)	UPMC <i>for Life</i> HMO Rx Enhanced (HMO)
<ul style="list-style-type: none"> • \$78 per month. In addition, you must keep paying your Medicare Part B premium. 	<ul style="list-style-type: none"> • \$223 per month. In addition, you must keep paying your Medicare Part B premium.
<ul style="list-style-type: none"> • This plan does not have a deductible. 	<ul style="list-style-type: none"> • This plan does not have a deductible.
<ul style="list-style-type: none"> • 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. • Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$3,400 for services you receive from in-network providers. • 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. • Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. 	<ul style="list-style-type: none"> • 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. • Your yearly limit(s) in this plan: <ul style="list-style-type: none"> • \$3,400 for services you receive from in-network providers. • 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. • Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

	<p style="text-align: center;">UPMC <i>for Life</i> (HMO)</p>	<p style="text-align: center;">UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</p>
<p>Is there a limit on how much the plan will pay?</p>	<ul style="list-style-type: none"> • Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. 	<ul style="list-style-type: none"> • Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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*
HMO Rx (HMO)**

- Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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

- Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:
SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
OUTPATIENT CARE AND SERVICES		
Acupuncture and Other Alternative Therapies	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
Ambulance	<ul style="list-style-type: none"> • \$125 copay per one-way trip 	<ul style="list-style-type: none"> • You pay nothing per one-way trip (after you pay your deductible)
Chiropractic Care	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
Dental Services	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 <ul style="list-style-type: none"> • Preventive dental services: <ul style="list-style-type: none"> ○ Dental x-ray(s) (for up to 1 every three years): \$15 copay • Dental services: \$15 copay for a single office visit that includes: <ul style="list-style-type: none"> ○ Cleaning (for up to 1 every six months) ○ Oral exam (for up to 1 every six months)
Diabetes Supplies and Services	<ul style="list-style-type: none"> • Diabetes monitoring supplies: \$10-50 copay, depending on the supply • Diabetes self-management training: You pay nothing 	<ul style="list-style-type: none"> • Diabetes monitoring supplies: 10% of the cost • Diabetes self-management training: You pay nothing

UPMC <i>for Life</i> HMO Rx (HMO)	UPMC <i>for Life</i> HMO Rx Enhanced (HMO)
<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
<ul style="list-style-type: none"> • \$100 copay per one-way trip 	<ul style="list-style-type: none"> • \$100 copay per one-way trip
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$40 copay</p> <ul style="list-style-type: none"> • Preventive dental services: <ul style="list-style-type: none"> ○ Dental x-ray(s) (for up to 1 every three years): \$15 copay • Dental services: \$15 copay for a single office visit that includes: <ul style="list-style-type: none"> ○ Cleaning (for up to 1 every six months) ○ Oral exam (for up to 1 every six months) 	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$25 copay</p> <ul style="list-style-type: none"> • Preventive dental services: <ul style="list-style-type: none"> ○ Dental x-ray(s) (for up to 1 every three years): \$15 copay • Dental services: \$15 copay for a single office visit that includes: <ul style="list-style-type: none"> ○ Cleaning (for up to 1 every six months) ○ Oral exam (for up to 1 every six months)
<ul style="list-style-type: none"> • Diabetes monitoring supplies: \$10-50 copay, depending on the supply • Diabetes self-management training: You pay nothing 	<ul style="list-style-type: none"> • Diabetes monitoring supplies: \$10-30 copay, depending on the supply • Diabetes self-management training: You pay nothing

	<p style="text-align: center;">UPMC <i>for Life</i> (HMO)</p>	<p style="text-align: center;">UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</p>
<p>Diabetes Supplies and Services <i>(continued)</i></p>	<ul style="list-style-type: none"> • Therapeutic shoes or inserts: \$25 copay <p>If the doctor provides you additional services, separate cost-sharing may apply.</p> <p>Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.</p>	<ul style="list-style-type: none"> • Therapeutic shoes or inserts: 10% of the cost <p>If the doctor provides you additional services, separate cost-sharing may apply.</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>
<p>Diagnostic Tests, Lab and Radiology Services, and X-Rays¹</p>	<ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans): \$110 copay • Diagnostic tests and procedures: \$0-5 copay, depending on the service • Lab services: \$0-5 copay, depending on the service • Outpatient x-rays: \$30 copay • Therapeutic radiology services (such as radiation treatment for cancer): \$25 copay <p>If the doctor provides you additional services, separate cost-sharing may apply.</p>	<ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans): \$50 copay • Diagnostic tests and procedures: \$0-5 copay, depending on the service • Lab services: \$0-5 copay, depending on the service • Outpatient x-rays: \$10 copay • Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing <p>If the doctor provides you additional services, separate cost-sharing may apply.</p> <p>Diagnostic and therapeutic radiology services, and outpatient x-rays: (after you pay your deductible)</p>

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

- Therapeutic shoes or inserts: \$25 copay

If the doctor provides you additional services, separate cost-sharing may apply.

Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.

- Diagnostic radiology services (such as MRIs, CT scans): \$150 copay
- Diagnostic tests and procedures: \$0-5 copay, depending on the service
- Lab services: \$0-5 copay, depending on the service
- Outpatient x-rays: \$40 copay
- Therapeutic radiology services (such as radiation treatment for cancer): \$25 copay

If the doctor provides you additional services, separate cost-sharing may apply

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

- Therapeutic shoes or inserts: \$15 copay

If the doctor provides you additional services, separate cost-sharing may apply.

Diabetic supplies and services are limited to specific manufacturers, products, and/or brands.

- Diagnostic radiology services (such as MRIs, CT scans): \$75 copay
- Diagnostic tests and procedures: You pay nothing
- Lab services: You pay nothing
- Outpatient x-rays: \$20 copay
- Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing

If the doctor provides you additional services, separate cost-sharing may apply

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
Doctor's Office Visits	<ul style="list-style-type: none"> • Primary care physician visit: \$5 copay • Specialist visit: \$45 copay 	<ul style="list-style-type: none"> • Primary care physician visit: \$5 copay • Specialist visit: \$50 copay
Durable Medical Equipment <i>(wheelchairs, oxygen, etc.)</i> ¹	<ul style="list-style-type: none"> • 20% of the cost 	<ul style="list-style-type: none"> • You pay nothing (after you pay your deductible)
Emergency Care	<ul style="list-style-type: none"> • \$65 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. 	<ul style="list-style-type: none"> • \$65 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.
Foot Care <i>(podiatry services)</i>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay
Hearing Services	<ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: \$45 copay 	<ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: \$50 copay
Home Health Care ¹	<ul style="list-style-type: none"> • You pay nothing 	<ul style="list-style-type: none"> • You pay nothing (after you pay your deductible)

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<ul style="list-style-type: none"> • Primary care physician visit: \$5 copay • Specialist visit: \$40 copay 	<ul style="list-style-type: none"> • Primary care physician visit: \$5 copay • Specialist visit: \$25 copay
<ul style="list-style-type: none"> • 20% of the cost 	<ul style="list-style-type: none"> • 20% of the cost
<ul style="list-style-type: none"> • \$65 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. 	<ul style="list-style-type: none"> • \$65 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.
<ul style="list-style-type: none"> • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay • Routine foot care (for up to 4 visit(s) every year): \$40 copay 	<ul style="list-style-type: none"> • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$25 copay • Routine foot care (for up to 4 visit(s) every year): \$25 copay
<ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: \$40 copay 	<ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: \$25 copay • Routine hearing exam (for up to 1 every year): \$25 copay • Hearing aid fitting/evaluation (for up to 1 every three years): \$25 copay • Hearing aid: you pay nothing • Our plan pays up to \$1,500 every three years for hearing aids.
<ul style="list-style-type: none"> • You pay nothing 	<ul style="list-style-type: none"> • You pay nothing

	<p style="text-align: center;">UPMC for Life (HMO)</p>	<p style="text-align: center;">UPMC for Life HMO Deductible with Rx (HMO)</p>
<p>Mental Health Care¹</p>	<p>Inpatient visit:</p> <ul style="list-style-type: none"> • 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. • Our plan covers 90 days for an inpatient hospital stay. • 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. • \$350 copay per stay • Outpatient group therapy visit: \$40 copay • Outpatient individual therapy visit: \$40 copay 	<p>Inpatient visit:</p> <ul style="list-style-type: none"> • 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. • Our plan covers 90 days for an inpatient hospital stay. • 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. • \$200 copay per stay • Outpatient group therapy visit: \$40 copay • Outpatient individual therapy visit: \$40 copay <p>Inpatient visit: (after you pay your deductible)</p>
<p>Outpatient Rehabilitation</p>	<ul style="list-style-type: none"> • 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 • Occupational therapy visit: \$40 copay • Physical therapy and speech and language therapy visit: \$40 copay 	<ul style="list-style-type: none"> • 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 • Occupational therapy visit: You pay nothing • Physical therapy and speech and language therapy visit: You pay nothing <p>(after you pay your deductible)</p>

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

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

Inpatient visit:

- 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.
- Our plan covers 90 days for an inpatient hospital stay.
- 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.
- \$350 copay per stay
- Outpatient group therapy visit: \$40 copay
- Outpatient individual therapy visit: \$40 copay

- 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
- Occupational therapy visit: \$40 copay
- Physical therapy and speech and language therapy visit: \$40 copay

Inpatient visit:

- Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care does not apply applies to inpatient mental services provided in a general hospital.
- Our plan covers 90 days for an inpatient hospital stay.
- 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.
- \$125 copay per stay
- Outpatient group therapy visit: \$25 copay
- Outpatient individual therapy visit: \$25 copay

\$375 maximum out-of-pocket limit every year. This is a combined limit with inpatient hospital care.

- 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
- Occupational therapy visit: \$25 copay
- Physical therapy and speech and language therapy visit: \$25 copay

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
Outpatient Substance Abuse	<ul style="list-style-type: none"> • Group therapy visit: \$40 copay • Individual therapy visit: \$40 copay 	<ul style="list-style-type: none"> • Group therapy visit: \$40 copay • Individual therapy visit: \$40 copay
Outpatient Surgery¹	<ul style="list-style-type: none"> • Ambulatory surgical center: \$225 copay • Outpatient hospital: \$0-225 copay, depending on the service 	<ul style="list-style-type: none"> • Ambulatory surgical center: \$125 copay • Outpatient hospital: \$0-125 copay, depending on the service (after you pay your deductible)
Over-the-Counter Items	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
Prosthetic Devices (braces, artificial limbs, etc.)	<ul style="list-style-type: none"> • Prosthetic devices: 20% of the cost • Related medical supplies: 20% of the cost 	<ul style="list-style-type: none"> • Prosthetic devices: You pay nothing • Related medical supplies: You pay nothing (after you pay your deductible)
Renal Dialysis	<ul style="list-style-type: none"> • 20% of the cost 	<ul style="list-style-type: none"> • 20% of the cost
Transportation	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
Urgent Care	<ul style="list-style-type: none"> • \$45 copay 	<ul style="list-style-type: none"> • \$50 copay

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<ul style="list-style-type: none"> • Group therapy visit: \$40 copay • Individual therapy visit: \$40 copay 	<ul style="list-style-type: none"> • Group therapy visit: \$25 copay • Individual therapy visit: \$25 copay
<ul style="list-style-type: none"> • Ambulatory surgical center: \$250 copay • Outpatient hospital: \$0-250 copay, depending on the service 	<ul style="list-style-type: none"> • Ambulatory surgical center: \$80 copay • Outpatient hospital: \$0-80 copay, depending on the service
<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
<ul style="list-style-type: none"> • Prosthetic devices: 20% of the cost • Related medical supplies: 20% of the cost 	<ul style="list-style-type: none"> • Prosthetic devices: 20% of the cost • Related medical supplies: 20% of the cost
<ul style="list-style-type: none"> • 20% of the cost 	<ul style="list-style-type: none"> • 20% of the cost
<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Not covered
<ul style="list-style-type: none"> • \$40 copay 	<ul style="list-style-type: none"> • \$25 copay

	<p style="text-align: center;">UPMC for Life (HMO)</p>	<p style="text-align: center;">UPMC for Life HMO Deductible with Rx (HMO)</p>
<p>Vision Services</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-45 copay, depending on the service</p> <ul style="list-style-type: none"> • Routine eye exam (for up to 1 every two years): You pay nothing • Contact lenses (for up to 1 every two years): You pay nothing • Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing • Eyeglasses or contact lenses after cataract surgery: You pay nothing <p>Our plan pays up to \$150 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-50 copay, depending on the service</p> <ul style="list-style-type: none"> • Routine eye exam (for up to 1 every two years): You pay nothing • Contact lenses (for up to 1 every two years): You pay nothing • Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing • Eyeglasses or contact lenses after cataract surgery: You pay nothing <p>Our plan pays up to \$150 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>
<p>Preventive Care</p>	<ul style="list-style-type: none"> • You pay nothing <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy 	<ul style="list-style-type: none"> • You pay nothing <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy

<p style="text-align: center;">UPMC <i>for Life</i> HMO Rx (HMO)</p>	<p style="text-align: center;">UPMC <i>for Life</i> HMO Rx Enhanced (HMO)</p>
<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service</p> <ul style="list-style-type: none"> • Routine eye exam (for up to 1 every two years): You pay nothing • Contact lenses (for up to 1 every two years): You pay nothing • Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing • Eyeglasses or contact lenses after cataract surgery: You pay nothing <p>Our plan pays up to \$175 every two years for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-25 copay, depending on the service</p> <ul style="list-style-type: none"> • Routine eye exam (for up to 1 every year): You pay nothing • Contact lenses (for up to 1 every year): You pay nothing • Eyeglasses (frames and lenses) (for up to 1 every year): You pay nothing • Eyeglasses or contact lenses after cataract surgery: You pay nothing <p>Our plan pays up to \$200 every year for routine eye exams, contact lenses, and eyeglasses (frames and lenses).</p>
<ul style="list-style-type: none"> • You pay nothing <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy 	<ul style="list-style-type: none"> • You pay nothing <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy

	<p align="center">UPMC <i>for Life</i> (HMO)</p>	<p align="center">UPMC <i>for Life</i> HMO Deductible with Rx (HMO)</p>
<p>Preventive Care <i>(continued)</i></p>	<ul style="list-style-type: none"> • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<p>Hospice</p>	<ul style="list-style-type: none"> • You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. 	<ul style="list-style-type: none"> • You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

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

- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots

- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

- You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

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

- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots

- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

- You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
INPATIENT CARE		
Inpatient Hospital Care¹	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> • \$350 copay per stay • You pay nothing per day for days 91 and beyond 	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> • \$200 copay per stay • You pay nothing per day for days 91 and beyond <p>(after you pay your deductible)</p>
Inpatient Mental Health Care	<ul style="list-style-type: none"> • For inpatient mental health care, see the "Mental Health Care" section of this booklet. 	<ul style="list-style-type: none"> • For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)¹	<ul style="list-style-type: none"> • Our plan covers up to 100 days in a SNF. • \$25 copay per day for days 1 through 5 • \$40 copay per day for days 6 through 20 • \$80 copay per day for days 21 through 100 	<ul style="list-style-type: none"> • Our plan covers up to 100 days in a SNF. • \$0 copay per day for days 1 through 20 • \$125 copay per day for days 21 through 100
PRESCRIPTION DRUG BENEFITS		
How much do I pay?	<ul style="list-style-type: none"> • For Part B drugs such as chemotherapy drugs¹: 20% of the cost • Other Part B drugs¹: 20% of the cost • Our plan does not cover Part D prescription drug. 	<ul style="list-style-type: none"> • For Part B drugs such as chemotherapy drugs¹: 20% of the cost • Other Part B drugs¹: 20% of the cost

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

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

Our plan covers an unlimited number of days for an inpatient hospital stay.

- \$350 copay per stay
- You pay nothing per day for days 91 and beyond

- For inpatient mental health care, see the "Mental Health Care" section of this booklet.

- Our plan covers up to 100 days in a SNF.
- \$25 copay per day for days 1 through 5
- \$40 copay per day for days 6 through 20
- \$80 copay per day for days 21 through 100

Our plan covers an unlimited number of days for an inpatient hospital stay.

- \$125 copay per stay
- You pay nothing per day for days 91 and beyond

\$375 maximum out-of-pocket limit every year. This is a combined limit with inpatient mental health care.

- For inpatient mental health care, see the "Mental Health Care" section of this booklet.

- Our plan covers up to 100 days in a SNF.
- \$10 copay per day for days 1 through 20
- \$60 copay per day for days 21 through 73
- \$0 copay per day for days 74 through 100

- For Part B drugs such as chemotherapy drugs¹: 20% of the cost
- Other Part B drugs¹: 20% of the cost

- For Part B drugs such as chemotherapy drugs¹: 20% of the cost
- Other Part B drugs¹: 20% of the cost

	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
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Initial Coverage

- You pay the following until your total yearly drug costs reach \$2,960. 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

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	\$10 copay	\$30 copay
Tier 2 (Preferred Brand)	\$45 copay	\$135 copay
Tier 3 (Non-Preferred Brand)	\$95 copay	\$285 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	\$0	\$0

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

- You pay the following until your total yearly drug costs reach \$2,960. 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

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	\$8 copay	\$24 copay
Tier 2 (Preferred Brand)	\$45 copay	\$135 copay
Tier 3 (Non-Preferred Brand)	\$95 copay	\$285 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	\$0	\$0

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

- You pay the following until your total yearly drug costs reach \$2,960. 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

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	\$8 copay	\$24 copay
Tier 2 (Preferred Brand)	\$45 copay	\$135 copay
Tier 3 (Non-Preferred Brand)	\$95 copay	\$285 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered
Tier 5 (Select Care Drugs)	\$0	\$0

Benefit	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)																		
Initial Coverage <i>(continued)</i>		<p data-bbox="967 310 1455 342">Standard Mail-Order Cost-Sharing</p> <table border="1" data-bbox="980 384 1448 1255"> <thead> <tr> <th data-bbox="980 384 1143 573">Tier</th> <th data-bbox="1143 384 1295 573">One-month supply</th> <th data-bbox="1295 384 1448 573">Three-month supply</th> </tr> </thead> <tbody> <tr> <td data-bbox="980 573 1143 695">Tier 1 (Generic)</td> <td data-bbox="1143 573 1295 695">Not Offered</td> <td data-bbox="1295 573 1448 695">\$20 copay</td> </tr> <tr> <td data-bbox="980 695 1143 831">Tier 2 (Preferred Brand)</td> <td data-bbox="1143 695 1295 831">Not Offered</td> <td data-bbox="1295 695 1448 831">\$112.50 copay</td> </tr> <tr> <td data-bbox="980 831 1143 982">Tier 3 (Non-Preferred Brand)</td> <td data-bbox="1143 831 1295 982">Not Offered</td> <td data-bbox="1295 831 1448 982">\$285 copay</td> </tr> <tr> <td data-bbox="980 982 1143 1104">Tier 4 (Specialty Tier)</td> <td data-bbox="1143 982 1295 1104">33% of the cost</td> <td data-bbox="1295 982 1448 1104">Not Offered</td> </tr> <tr> <td data-bbox="980 1104 1143 1255">Tier 5 (Select Care Drugs)</td> <td data-bbox="1143 1104 1295 1255">Not Offered</td> <td data-bbox="1295 1104 1448 1255">\$0</td> </tr> </tbody> </table> <ul data-bbox="967 1297 1464 1587" style="list-style-type: none"> • 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. 	Tier	One-month supply	Three-month supply	Tier 1 (Generic)	Not Offered	\$20 copay	Tier 2 (Preferred Brand)	Not Offered	\$112.50 copay	Tier 3 (Non-Preferred Brand)	Not Offered	\$285 copay	Tier 4 (Specialty Tier)	33% of the cost	Not Offered	Tier 5 (Select Care Drugs)	Not Offered	\$0
Tier	One-month supply	Three-month supply																		
Tier 1 (Generic)	Not Offered	\$20 copay																		
Tier 2 (Preferred Brand)	Not Offered	\$112.50 copay																		
Tier 3 (Non-Preferred Brand)	Not Offered	\$285 copay																		
Tier 4 (Specialty Tier)	33% of the cost	Not Offered																		
Tier 5 (Select Care Drugs)	Not Offered	\$0																		

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

Standard Mail-Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	Not Offered	\$16 copay
Tier 2 (Preferred Brand)	Not Offered	\$112.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	\$285 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

Tier	One-month supply	Three-month supply
Tier 1 (Generic)	Not Offered	\$16 copay
Tier 2 (Preferred Brand)	Not Offered	\$112.50 copay
Tier 3 (Non-Preferred Brand)	Not Offered	\$285 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.

Benefit	UPMC <i>for Life</i> (HMO)	UPMC <i>for Life</i> HMO Deductible with Rx (HMO)
Coverage Gap		<ul style="list-style-type: none"> • 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 \$2,960. • After you enter the coverage gap, you pay 45% of the plan's cost for covered brand-name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage		<ul style="list-style-type: none"> • After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach \$4,700, you pay the greater of: <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.

**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 \$2,960.
- After you enter the coverage gap, you pay 45% of the plan's cost for covered brand-name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, 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 \$4,700, you pay the greater of:
 - 5% of the cost, or
 - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 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 \$2,960.
- After you enter the coverage gap, you pay 45% of the plan's cost for covered brand-name drugs and 65% of the plan's cost for covered generic drugs until your costs total \$4,700, 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 \$4,700, you pay the greater of:
 - 5% of the cost, or
 - \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.

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 at no additional cost:

- UPMC *for Life* offers a fitness center membership through its Silver&Fit[®] 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.
- 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.

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。

