2015
Summary of Benefits

PPO
Western Pennsylvania
H5533

UPMC *for Life*
UPMC Health Plan Medicare Program

H5533_15_2026 Accepted

UPMC *for Life* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)
(a Medicare Advantage Preferred Provider Organization (PPO) offered by UPMC Health Network, 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* PPO High Deductible with Rx or PPO Rx Enhanced (PPO)**).
Tips for comparing your Medicare choices
This Summary of Benefits booklet gives you a summary of what **UPMC *for Life* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)** cover 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* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)**
• 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* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)**

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* PPO High Deductible with Rx and PPO Rx Enhanced (PPO) 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* PPO High Deductible with Rx or PPO Rx Enhanced (PPO),** 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* PPO High Deductible with Rx and PPO Rx Enhanced (PPO) have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

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.

We 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?

Our plans 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 *for Life* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
How much is the monthly premium?	• $39 per month. In addition, you must keep paying your Medicare Part B premium.	• $139 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	• This plan has deductibles for some hospital and medical services. • $1,250 per year for some in-network and out-of-network services. • This plan does not have a deductible for Part D prescription drugs.	• This plan has deductibles for some hospital and medical services. • $500 per year for out-of-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?	• 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:
	  ◦ $6,700 for services you receive from in-network providers.
	  ◦ $10,000 for services you receive from any provider.
	• Your limit for services received from in-network providers will count toward this limit.
		• 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:
		  ◦ $6,700 for services you receive from in-network providers.
		  ◦ $10,000 for services you receive from any provider.
		• Your limit for services received from in-network providers will count toward this limit.

	UPMC *for Life* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
Is there any limit on how much I will pay for my covered services? *(continued)*	• 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.	• 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.
Is there a limit on how much the plan will pay?	• Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	• 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.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:
SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.

	UPMC *for Life* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
OUTPATIENT CARE AND SERVICES		
Acupuncture and Other Alternative Therapies	• Not covered	• Not covered
Ambulance	• In-network: You pay nothing • Out-of-network: 30% of the cost per one-way trip (In-and out-of-network: after you pay your deductible)	• In-network: $100 copay • Out-of-network: 30% of the cost per one-way trip (Out-of-network: after you pay your deductible)
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $40 copay Routine chiropractic visit (for up to 8 every year): • In-network: $20 copay • Out-of-network: $40 copay (Out-of-network: after you pay your deductible)	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $30 copay Routine chiropractic visit (for up to 8 every year): • In-network: $20 copay • Out-of-network: $30 copay (Out-of-network: after you pay your deductible)

<table>
<tr><th></th><th>UPMC for Life
PPO High Deductible with Rx (PPO)</th><th>UPMC for Life
PPO Rx Enhanced (PPO)</th></tr>
<tr><td>Dental Services</td><td>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):
• In-network: $50 copay
• Out-of-network: $60 copay
Preventive dental services:
• Dental x-ray(s) (for up to 1 every three years):
o In-network: $15 copay
o Out-of-network: 50% of the cost
• A single office visit that includes:
o Cleaning (for up to 1 every six months)
o Oral exam (for up to 1 every six months)
▪ In-network: $15 copay
▪ Out-of-network: 50% of the cost
Limited dental services: (Out-of-network: after you pay your deductible)</td><td>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):
• In-network: $40 copay
• Out-of-network: $50 copay
Preventive dental services:
• Dental x-ray(s) (for up to 1 every three years):
o In-network: $15 copay
o Out-of-network: 50% of the cost
• A single office visit that includes:
o Cleaning (for up to 1 every six months)
o Oral exam (for up to 1 every six months)
▪ In-network: $15 copay
▪ Out-of-network: 50% of the cost
Limited dental services: (Out-of-network: after you pay your deductible)</td></tr>
<tr><td>Diabetes Supplies and Services</td><td>Diabetes monitoring supplies:
• In-network: 10% of the cost
• Out-of-network: 50% of the cost
Diabetes self-management training:
• In-network: You pay nothing
• Out-of-network: 50% of the cost</td><td>Diabetes monitoring supplies:
• In-network: 20% of the cost
• Out-of-network: 50% of the cost
Diabetes self-management training:
• In-network: You pay nothing
• Out-of-network: 30% of the cost</td></tr>
</table>

	UPMC *for Life* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
Diabetes Supplies and Services *(continued)*	Therapeutic shoes or inserts: • In-network: 10% of the cost • Out-of-network: 50% of the cost 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. Supplies: (In-and out-of-network: after you pay your deductible) Training: (Out-of-network: after you pay your deductible)	Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 50% of the cost 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. (Out-of-network: after you pay your deductible)
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $50 copay • Out-of-network: 30% of the cost Diagnostic tests and procedures: • In-network: $0-5 copay, depending on the service • Out-of-network: 30% of the cost Lab services: • In-network: $0-5 copay, depending on the service • Out-of-network: 30% of the cost Outpatient x-rays: • In-network: $10 copay • Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $100 copay • Out-of-network: 30% of the cost Diagnostic tests and procedures: • In-network: $0-5 copay, depending on the service • Out-of-network: 30% of the cost Lab services: • In-network: $0-5 copay, depending on the service • Out-of-network: 30% of the cost Outpatient x-rays: • In-network: $20 copay • Out-of-network: 30% of the cost

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Diagnostic Tests, Lab and Radiology Services, and X-Rays[1] *(continued)*	Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 30% of the cost If the doctor provides you additional services, separate cost-sharing may apply. Diagnostic and therapeutic radiology services, and outpatient x-rays: (In- and out-of-network: after you pay your deductible) Labs, diagnostic tests, and procedures: (Out-of-network: after you pay your deductible)	Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $25 copay • Out-of-network: 30% of the cost If the doctor provides you additional services, separate cost-sharing may apply. (Out-of-network: after you pay your deductible)
Doctor's Office Visits	Primary care physician visit: • In-network: $10 copay • Out-of-network: $40 copay Specialist visit: • In-network: $50 copay • Out-of-network: $60 copay (Out-of-network: after you pay your deductible)	Primary care physician visit: • In-network: $5 copay • Out-of-network: $30 copay Specialist visit: • In-network: $40 copay • Out-of-network: $50 copay (Out-of-network: after you pay your deductible)
Durable Medical Equipment *(wheelchairs, oxygen, etc.)[1]*	• In-network: 15% of the cost • Out-of-network: 50% of the cost (Out-of-network: after you pay your deductible)	• In-network: 15% of the cost • Out-of-network: 50% of the cost (Out-of-network: after you pay your deductible)

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Emergency Care	• $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.	• $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 *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: $60 copay Routine foot care (for up to 8 visit(s) every year): • In-network: $50 copay • Out-of-network: $60 copay (Out-of-network: after you pay your deductible)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $40 copay • Out-of-network: $50 copay Routine foot care (for up to 8 visit(s) every year): • In-network: $40 copay • Out-of-network: $50 copay (Out-of-network: after you pay your deductible)
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $50 copay • Out-of-network: $60 copay (Out-of-network: after you pay your deductible)	Exam to diagnose and treat hearing and balance issues: • In-network: $40 copay • Out-of-network: $50 copay Routine hearing exam (for up to 1 every year): • In-network: $40 copay • Out-of-network: $50 copay Hearing aid fitting/evaluation (for up to 1 every three years): • In-network: $40 copay • Out-of-network: $50 copay

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Hearing Services *(continued)*		Hearing aid: • In-network: You pay nothing • Out-of-network: 50% of the cost Our plan pays up to $1,500 every three years for hearing aids from any provider. Exam to diagnose and treat hearing and balance issues: (Out-of-network: after you pay your deductible)
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: 30% of the cost (In-and out-of-network: after you pay your deductible)	• In-network: You pay nothing • Out-of-network: 30% of the cost (Out-of-network: after you pay your deductible)
Mental Health Care[1]	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.	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.

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Mental Health Care[1]
(continued)
	• In-network:
	  o $250 copay per stay
	• Out-of-network:
	  o 30% of the cost per stay
	Outpatient group therapy visit:
	  o In-network: $40 copay
	  o Out-of-network: $60 copay
	Outpatient individual therapy visit:
	  o In-network: $40 copay
	  o Out-of-network: $60 copay
	
	Inpatient visit: (In-and out-of-network: after you pay your deductible)
	Outpatient group and individual therapy visits: (Out-of-network: after you pay your deductible)
		• In-network:
		  o $250 copay per stay
		• Out-of-network:
		  o 30% of the cost per stay
		Outpatient group therapy visit:
		  o In-network: $40 copay
		  o Out-of-network: $50 copay
		Outpatient individual therapy visit:
		  o In-network: $40 copay
		  o Out-of-network: $50 copay
		
		(Out-of-network: after you pay your deductible)
		
		$1,000 maximum out-of-pocket limit every year. This is a combined limit with inpatient hospital care.

Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: $50 copay Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: $50 copay

	UPMC *for Life* **PPO High Deductible with Rx (PPO)**	UPMC *for Life* **PPO Rx Enhanced (PPO)**
Outpatient Rehabilitation *(continued)*	Cardiac (heart) rehab services: (In- and out-of-network: after you pay your deductible) Occupational therapy, physical therapy, and speech and language therapy visits: (Out-of-network: after you pay your deductible)	(Out-of-network: after you pay your deductible)
Outpatient Substance Abuse	Group therapy visit: • In-network: $40 copay • Out-of-network: $60 copay Individual therapy visit: • In-network: $40 copay • Out-of-network: $60 copay (Out-of-network: after you pay your deductible)	Group therapy visit: • In-network: $40 copay • Out-of-network: $50 copay Individual therapy visit: • In-network: $40 copay • Out-of-network: $50 copay (Out-of-network: after you pay your deductible)
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $125 copay • Out-of-network: 30% of the cost Outpatient hospital: • In-network: $0-125 copay, depending on the service • Out-of-network: 30% of the cost (In-and out-of-network: after you pay your deductible)	Ambulatory surgical center: • In-network: $150 copay • Out-of-network: 30% of the cost Outpatient hospital: • In-network: $0-150 copay, depending on the service • Out-of-network: 30% of the cost (Out-of-network: after you pay your deductible
Over-the-Counter Items	• Not covered	• Not covered

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Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: • In-network: 15% of the cost • Out-of-network: 50% of the cost Related medical supplies: • In-network: 15% of the cost • Out-of-network: 50% of the cost (Out-of-network: after you pay your deductible)	Prosthetic devices: • In-network: 15% of the cost • Out-of-network: 50% of the cost Related medical supplies: • In-network: 15% of the cost • Out-of-network: 50% of the cost (Out-of-network: after you pay your deductible)
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 30% of the cost (In-and out-of-network: after you pay your deductible)	• In-network: 20% of the cost • Out-of-network: 30% of the cost (Out-of-network: after you pay your deductible)
Transportation	• Not covered	• Not covered
Urgent Care	• $50 copay	• $40 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-50 copay, depending on the service • Out-of-network: $60 copay Routine eye exam (for up to 1 every two years): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every two years for routine eye exams from any provider.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-40 copay, depending on the service • Out-of-network: $50 copay Routine eye exam (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $200 every year for routine eye exams from any provider.

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Vision Services *(continued)*	Contact lenses (for up to 1 every two years): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses) (for up to 1 every two years): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 30% of the cost Our plan pays up to $100 every two years for contact lenses and eyeglasses (frames and lenses) from any provider. Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) and eyeglasses and contact lenses after cataract surgery: (Out-of-network: after you pay your deductible)	Contact lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses) (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 30% of the cost Our plan pays up to $200 every year for contact lenses and eyeglasses (frames and lenses) from any provider. Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) and eyeglasses and contact lenses after cataract surgery: (Out-of-network: after you pay your deductible)
Preventive Care	• In-network: You pay nothing • Out-of-network: 30% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram)	• In-network: You pay nothing • Out-of-network: 30% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram)

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Preventive Care *(continued)*	• 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 • 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.	• 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 • 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.

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Hospice	• 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.	• 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.
INPATIENT CARE		
Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: o $250 copay per stay o You pay nothing per day for days 91 and beyond • Out-of-network: o 30% of the cost per stay (In-and out-of-network: after you pay your deductible)	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: o $250 copay per stay o You pay nothing per day for days 91 and beyond • Out-of-network: o 30% of the cost per stay (Out-of-network: after you pay your deductible) (In-network: $1,000 maximum out-of-pocket limit every year. This is a combined limit with inpatient mental health care.)
Inpatient Mental Health Care	• For inpatient mental health care, see the "Mental Health Care" section of this booklet.	• For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • In-network: o $0 copay per day for days 1 through 20 o $125 copay per day for days 21 through 100 • Out-of-network: o 30% of the cost per stay (Out-of-network: after you pay your deductible)	Our plan covers up to 100 days in a SNF. • In-network: o $0 copay per day for days 1 through 20 o $125 copay per day for days 21 through 100 • Out-of-network: o 30% of the cost per stay (Out-of-network: after you pay your deductible)

	UPMC *for Life* **PPO High Deductible with Rx (PPO)**	UPMC *for Life* **PPO Rx Enhanced (PPO)**
PRESCRIPTION DRUG BENEFITS		
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 50% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 50% of the cost (Out-of-network: after you pay your deductible)	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 30% of the cost Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 30% of the cost (Out-of-network: after you pay your deductible) (In-network: $5,000 out-of-pocket limit every year.)

<table>
<tr><th></th><th>UPMC for Life
PPO High Deductible with Rx (PPO)</th><th>UPMC for Life
PPO Rx Enhanced (PPO)</th></tr>
<tr><td>Initial Coverage</td>
<td>

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

	UPMC *for Life* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
Initial Coverage ***(continued)***	**Standard Mail-Order Cost-Sharing**	**Standard Mail-Order Cost-Sharing**

UPMC *for Life* PPO High Deductible with Rx (PPO) — Standard Mail-Order Cost-Sharing

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

- 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* PPO Rx Enhanced (PPO) — Standard Mail-Order Cost-Sharing

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

- 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* PPO High Deductible with Rx (PPO)	UPMC *for Life* PPO Rx Enhanced (PPO)
Coverage Gap	• 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.	• 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	• 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.	• 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* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)

With **UPMC *for Life* PPO High Deductible with Rx and PPO Rx Enhanced (PPO)** 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 panggamot. 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 quí vị cần thông dịch viên xin gọi 1-877-539-3080 sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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.

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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 ما يتحدث العربية بمساعدتك. هذه خدمة مجانية .

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ございます。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。

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