



2009
**SUMMARY
OF
BENEFITS**

HMO

Ohio
H2169

UPMC *for Life*

UPMC Health Plan Medicare Program

**Introduction to the Summary of Benefits for
UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced
January 1, 2009 - December 31, 2009
Ohio - Contract Number H2169**

Thank you for your interest in UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced. Our plan is offered by UPMC Health Plan, Inc., a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover, or list every limitation or exclusion. To get a complete list of our benefits, please call UPMC *for Life* HMO, HMO Rx, or HMO Rx Enhanced and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan **only** at certain times. Please call UPMC *for Life* HMO, HMO Rx, or HMO Rx Enhanced at the telephone number listed at the end of this introduction or 1-800-

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

HOW CAN I COMPARE MY OPTIONS?

You can compare UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced AVAILABLE?

The service area for these plans includes the following counties: Belmont, and Jefferson Counties, OH. You must live in one of these areas to join the plan.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another

plan, you may do so only during certain times of the year. Please call Customer Service for more information.

WHO IS ELIGIBLE TO JOIN UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced?

You can join UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced plans unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced have formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory, or for an up-to-date list visit us at

www.upmchealthplan.com. Our Customer Service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither UPMC *for Life* HMO, HMO Rx, or HMO Rx Enhanced nor the Original Medicare Plan will pay for these services.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

UPMC *for Life* HMO does cover Medicare Part B prescription drugs. UPMC *for Life* HMO does **NOT** cover Medicare Part D prescription drugs.

UPMC *for Life* HMO Rx and HMO Rx Enhanced do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

UPMC *for Life* HMO Rx and HMO Rx Enhanced have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can

ask for a pharmacy directory or visit us at http://www.upmchealthplan.com/plan/medicare/pharmacy_index.html. Our Customer Service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

UPMC *for Life* HMO Rx and HMO Rx Enhanced use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at http://www.upmchealthplan.com/plan/medicare/pharmacy_index.html.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join UPMC *for Life* HMO Rx or HMO Rx Enhanced, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help, you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of UPMC *for Life* HMO Rx or HMO Rx Enhanced, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug,

and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may

offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact UPMC *for Life* HMO Rx and HMO Rx Enhanced for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal

disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

Please call UPMC Health Plan for more information about UPMC *for Life* HMO, HMO Rx, and HMO Rx Enhanced.
Visit us at www.upmchealthplan.com, or call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. – 8:00 p.m. Eastern.

Current members should call toll-free **1-877-539-3080** for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program. (TTY/TDD **1-800-361-2629**)

Prospective members should call toll-free **1-877-381-3765** for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program. (TTY/TDD **1-800-361-2629**)

Current members should call locally **1-877-539-3080** for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program. (TTY/TDD **1-800-361-2629**)

Prospective members should call locally **1-877-381-3765** for questions related to the Medicare Advantage program or Medicare Part D Prescription Drug program. (TTY/TDD **1-800-361-2629**)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or visit www.medicare.gov on the Web.

If you have special needs, this document may be available in other formats.

SUMMARY OF BENEFITS

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

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
IMPORTANT INFORMATION				
1. Premium and Other Important Information	<ul style="list-style-type: none"> • In 2009, the monthly Part B premium is \$96.40 and the yearly Part B deductible amount is \$135. • If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. 	<p>General</p> <ul style="list-style-type: none"> • \$28.20 monthly plan premium in addition to your monthly Medicare Part B premium. <p>In-Network</p> <ul style="list-style-type: none"> • \$3,100 in-network out-of-pocket limit. • All Medicare services covered under the out-of-pocket limit. • The out-of-pocket limit excludes the following non-Medicare covered services: <ul style="list-style-type: none"> • Routine hearing exams and hearing aids. • Routine vision exam and routine eyewear. 	<p>General</p> <ul style="list-style-type: none"> • \$59.00 monthly plan premium in addition to your monthly Medicare Part B premium. <p>In-Network</p> <ul style="list-style-type: none"> • \$3,100 in-network out-of-pocket limit. • All Medicare services covered under the out-of-pocket limit. • The out-of-pocket limit excludes the following non-Medicare covered services: <ul style="list-style-type: none"> • Routine hearing exams and hearing aids. • Routine vision exam and routine eyewear. 	<p>General</p> <ul style="list-style-type: none"> • \$84.70 monthly plan premium in addition to your monthly Medicare Part B premium. <p>In-Network</p> <ul style="list-style-type: none"> • \$3,100 in-network out-of-pocket limit. • All Medicare services covered under the out-of-pocket limit. • The out-of-pocket limit excludes the following non-Medicare covered services: <ul style="list-style-type: none"> • Routine hearing exams and hearing aids. • Routine vision exam and routine eyewear.

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<p>2. Doctor and Hospital Choice</p> <p>(For more information see Emergency – #15 and Urgently Needed Care – #16.)</p>	<ul style="list-style-type: none"> You may go to any doctor, specialist, or hospital that accepts Medicare. 	<p>In-Network</p> <ul style="list-style-type: none"> You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits. 	<p>In-Network</p> <ul style="list-style-type: none"> You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits. 	<p>In-Network</p> <ul style="list-style-type: none"> You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits.

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INPATIENT CARE				
3. Inpatient Hospital Care (includes substance abuse and rehabilitation services)	In 2009, the amounts for each benefit period are: <ul style="list-style-type: none"> • Days 1-60: \$1,068 deductible. • Days 61-90: \$267 per day. • Days 91-150: \$534 per lifetime reserve day. • Call 1-800 MEDICARE (1-800-633-4227) for information about lifetime reserve days. • Lifetime reserve days can only be used once. 	In-Network <ul style="list-style-type: none"> • \$250 copay for each Medicare-covered hospital stay. • \$0 copay for additional hospital days. • \$750 out-of-pocket limit every year. • No limit to the number of days covered by the plan each benefit period. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient hospital care. 	In-Network <ul style="list-style-type: none"> • \$250 copay for each Medicare-covered hospital stay. • \$0 copay for additional hospital days. • \$750 out-of-pocket limit every year. • No limit to the number of days covered by the plan each benefit period. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient hospital care. 	In-Network <ul style="list-style-type: none"> • \$100 copay for each Medicare-covered hospital stay. • \$0 copay for additional hospital days. • \$200 out-of-pocket limit every year. • No limit to the number of days covered by the plan each benefit period. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient hospital care.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Inpatient Hospital Care (continued)	<ul style="list-style-type: none"> A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. 			

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
<p>4. Inpatient Mental Health Care</p>	<ul style="list-style-type: none"> • Same deductible and copays as inpatient hospital care (See “Inpatient Hospital Care” above). • 190-day lifetime limit in a psychiatric hospital. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$250 copay for each Medicare-covered hospital stay. • The maximum out-of-pocket limit is covered under “Inpatient Hospital Care.” • You get up to 190 days in a psychiatric hospital in a lifetime. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient mental health care. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$250 copay for each Medicare-covered hospital stay. • The maximum out-of-pocket limit is covered under “Inpatient Hospital Care.” • You get up to 190 days in a psychiatric hospital in a lifetime. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient mental health care. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$100 copay for each Medicare-covered hospital stay. • The maximum out-of-pocket limit is covered under “Inpatient Hospital Care.” • You get up to 190 days in a psychiatric hospital in a lifetime. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. • See page 37 for additional information about inpatient mental health care.

Benefit Category	Original Medicare	UPMC for Life HMO	UPMC for Life HMO Rx	UPMC for Life HMO Rx Enhanced
<p>5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>In 2009, the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <ul style="list-style-type: none"> • Days 1-20: \$0 per day. • Days 21-100: \$133.50 per day. • 100 days for each benefit period. • A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. 	<p>General</p> <ul style="list-style-type: none"> • Authorization rules may apply. <p>In-Network For SNF stays:</p> <ul style="list-style-type: none"> • Days 1-15: \$0 copay per day. • Days 16-65: \$60 copay per day. • Days 66-100: \$0 copay per day. • \$3,000 out-of-pocket limit every year. • Plan covers up to 100 days each benefit period. • No prior hospital stay is required. • See pages 37 and 38 for additional information about skilled nursing facility care. 	<p>General</p> <ul style="list-style-type: none"> • Authorization rules may apply. <p>In-Network For SNF stays:</p> <ul style="list-style-type: none"> • Days 1-15: \$0 copay per day. • Days 16-65: \$60 copay per day. • Days 66-100: \$0 copay per day. • \$3,000 out-of-pocket limit every year. • Plan covers up to 100 days each benefit period. • No prior hospital stay is required. • See pages 37 and 38 for additional information about skilled nursing facility care. 	<p>General</p> <ul style="list-style-type: none"> • Authorization rules may apply. <p>In-Network For SNF stays:</p> <ul style="list-style-type: none"> • Days 1-15: \$0 copay per day. • Days 16-50: \$60 copay per day. • Days 51-100: \$0 copay per day. • \$2,100 out-of-pocket limit every year. • Plan covers up to 100 days each benefit period. • No prior hospital stay is required. • See pages 37 and 38 for additional information about skilled nursing facility care.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	<ul style="list-style-type: none"> \$0 copay. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered home health visits. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered home health visits. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered home health visits.
7. Hospice	<ul style="list-style-type: none"> You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice. 	General <ul style="list-style-type: none"> You must get care from a Medicare-certified hospice. 	General <ul style="list-style-type: none"> You must get care from a Medicare-certified hospice. 	General <ul style="list-style-type: none"> You must get care from a Medicare-certified hospice.

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OUTPATIENT CARE					
8.	Doctor Office Visits	<ul style="list-style-type: none"> 20% coinsurance. 	<p>General</p> <ul style="list-style-type: none"> See “Physical Exams” for more information. <p>In-Network</p> <ul style="list-style-type: none"> \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$30 copay for each in-area, network urgent care Medicare-covered visit. \$30 copay for each specialist visit for Medicare-covered benefits. 	<p>General</p> <ul style="list-style-type: none"> See “Physical Exams” for more information. <p>In-Network</p> <ul style="list-style-type: none"> \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$30 copay for each in-area, network urgent care Medicare-covered visit. \$30 copay for each specialist visit for Medicare-covered benefits. 	<p>General</p> <ul style="list-style-type: none"> See “Physical Exams” for more information. <p>In-Network</p> <ul style="list-style-type: none"> \$0 copay for each primary care doctor visit for Medicare-covered benefits. \$25 copay for each in-area, network urgent care Medicare-covered visit. \$25 copay for each specialist visit for Medicare-covered benefits.
9.	Chiropractic Services	<ul style="list-style-type: none"> Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider. 	<p>In-Network</p> <ul style="list-style-type: none"> \$30 copay for Medicare-covered visits. \$30 copay for up to 6 routine visits every year. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. 	<p>In-Network</p> <ul style="list-style-type: none"> \$30 copay for Medicare-covered visits. \$30 copay for up to 6 routine visits every year. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. 	<p>In-Network</p> <ul style="list-style-type: none"> \$25 copay for Medicare-covered visits. \$25 copay for up to 6 routine visits every year. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

Benefit Category		Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
10.	Podiatry Services	<ul style="list-style-type: none"> Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. 	In-Network <ul style="list-style-type: none"> \$30 copay for each Medicare-covered visit. \$30 copay for up to 4 routine visits every year. Medicare-covered podiatry benefits are for medically necessary foot care. 	In-Network <ul style="list-style-type: none"> \$30 copay for each Medicare-covered visit. \$30 copay for up to 4 routine visits every year. Medicare-covered podiatry benefits are for medically necessary foot care. 	In-Network <ul style="list-style-type: none"> \$25 copay for each Medicare-covered visit. \$25 copay for up to 4 routine visits every year. Medicare-covered podiatry benefits are for medically necessary foot care.
11.	Outpatient Mental Health Care	<ul style="list-style-type: none"> 50% coinsurance for most outpatient mental health services. 	In-Network <ul style="list-style-type: none"> \$30 copay for each Medicare-covered individual or group therapy visit. 	In-Network <ul style="list-style-type: none"> \$30 copay for each Medicare-covered individual or group therapy visit. 	In-Network <ul style="list-style-type: none"> \$25 copay for each Medicare-covered individual or group therapy visit.
12.	Outpatient Substance Abuse Care	<ul style="list-style-type: none"> 20% coinsurance. 	In-Network <ul style="list-style-type: none"> \$30 copay for Medicare-covered individual or group visits. 	In-Network <ul style="list-style-type: none"> \$30 copay for Medicare-covered individual or group visits. 	In-Network <ul style="list-style-type: none"> \$25 copay for Medicare-covered individual or group visits.

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13. Outpatient Services/Surgery	<ul style="list-style-type: none"> • 20% coinsurance for the doctor. • 20% of outpatient facility charges. 	In-Network <ul style="list-style-type: none"> • \$150 copay for each Medicare-covered ambulatory surgical center visit. • \$150 copay for each Medicare-covered outpatient hospital facility visit. • See page 38 for additional information about outpatient services/surgery. 	In-Network <ul style="list-style-type: none"> • \$150 copay for each Medicare-covered ambulatory surgical center visit. • \$150 copay for each Medicare-covered outpatient hospital facility visit. • See page 38 for additional information about outpatient services/surgery. 	In-Network <ul style="list-style-type: none"> • \$60 copay for each Medicare-covered ambulatory surgical center visit. • \$60 copay for each Medicare-covered outpatient hospital facility visit. • See page 38 for additional information about outpatient services/surgery.
14. Ambulance Services (medically necessary ambulance services)	<ul style="list-style-type: none"> • 20% coinsurance. 	In-Network <ul style="list-style-type: none"> • \$100 copay for Medicare-covered ambulance benefits. 	In-Network <ul style="list-style-type: none"> • \$100 copay for Medicare-covered ambulance benefits. 	In-Network <ul style="list-style-type: none"> • \$100 copay for Medicare-covered ambulance benefits.

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<p>15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<ul style="list-style-type: none"> • 20% coinsurance for the doctor. • 20% of facility charge or a set copay per emergency room visit. • You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. • NOT covered outside the U.S., except under limited circumstances. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered emergency room visits. <p>Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide coverage. <p>In- and Out-of-Network</p> <ul style="list-style-type: none"> • If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the emergency room visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered emergency room visits. <p>Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide coverage. <p>In- and Out-of-Network</p> <ul style="list-style-type: none"> • If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the emergency room visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered emergency room visits. <p>Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide coverage. <p>In- and Out-of-Network</p> <ul style="list-style-type: none"> • If you are admitted to the hospital within 3 days for the same condition, you pay \$0 for the emergency room visit.
<p>16. Urgently Needed Care (This is NOT emergency care and, in most cases, is out of the service area.)</p>	<ul style="list-style-type: none"> • 20% coinsurance or a set copay. • NOT covered outside the U.S., except under limited circumstances. 	<p>General</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered urgently needed care visits. • If you are admitted to the hospital within 3 days for the same condition, \$0 for the urgent care visit. 	<p>General</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered urgently needed care visits. • If you are admitted to the hospital within 3 days for the same condition, \$0 for the urgent care visit. 	<p>General</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered urgently needed care visits. • If you are admitted to the hospital within 3 days for the same condition, \$0 for the urgent care visit.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
17. Outpatient Rehabilitation Services (occupational therapy, physical therapy, speech and language therapy)	<ul style="list-style-type: none"> 20% coinsurance. 	In-Network <ul style="list-style-type: none"> \$30 copay for Medicare-covered occupational therapy visits. \$30 copay for Medicare-covered physical and/or speech/language therapy visits. 	In-Network <ul style="list-style-type: none"> \$30 copay for Medicare-covered occupational therapy visits. \$30 copay for Medicare-covered physical and/or speech/language therapy visits. 	In-Network <ul style="list-style-type: none"> \$15 copay for Medicare-covered occupational therapy visits. \$15 copay for Medicare-covered physical and/or speech/language therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	<ul style="list-style-type: none"> 20% coinsurance. 	General <ul style="list-style-type: none"> Authorization rules may apply. In-Network <ul style="list-style-type: none"> 0% to 20% of the cost for Medicare-covered items. See pages 37 and 38 for additional information about durable medical equipment. 	General <ul style="list-style-type: none"> Authorization rules may apply. In-Network <ul style="list-style-type: none"> 0% to 20% of the cost for Medicare-covered items. See pages 37 and 38 for additional information about durable medical equipment. 	General <ul style="list-style-type: none"> Authorization rules may apply. In-Network <ul style="list-style-type: none"> 0% to 20% of the cost for Medicare-covered items. See pages 37 and 38 for additional information about durable medical equipment.
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	<ul style="list-style-type: none"> 20% coinsurance. 	In-Network <ul style="list-style-type: none"> 20% of the cost for Medicare-covered items. 	In-Network <ul style="list-style-type: none"> 20% of the cost for Medicare-covered items. 	In-Network <ul style="list-style-type: none"> 20% of the cost for Medicare-covered items.

	Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
20.	Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	<ul style="list-style-type: none"> • 20% coinsurance. • Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. 	In-Network <ul style="list-style-type: none"> • \$0 copay for diabetes self-monitoring training. • \$0 copay for nutrition therapy for diabetes. • \$20 to \$60 copay for diabetes supplies. • See page 38 for additional information about diabetes self-monitoring training, nutrition therapy, and supplies. 	In-Network <ul style="list-style-type: none"> • \$0 copay for diabetes self-monitoring training. • \$0 copay for nutrition therapy for diabetes. • \$20 to \$60 copay for diabetes supplies. • See page 38 for additional information about diabetes self-monitoring training, nutrition therapy, and supplies. 	In-Network <ul style="list-style-type: none"> • \$0 copay for diabetes self-monitoring training. • \$0 copay for nutrition therapy for diabetes. • \$15 to \$45 copay for diabetes supplies. • See page 38 for additional information about diabetes self-monitoring training, nutrition therapy, and supplies.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
<p>21. Diagnostic Tests, X-Rays, and Lab Services</p>	<ul style="list-style-type: none"> • 20% coinsurance for diagnostic tests and x-rays. • \$0 copay for Medicare-covered lab services. • Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered: <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests. • \$15 copay for Medicare-covered x-rays. • \$50 copay for Medicare-covered diagnostic radiology services. • \$0 copay for Medicare-covered therapeutic radiology services. • See page 38 for additional information about diagnostic tests, x-rays, and lab services. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered: <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests. • \$15 copay for Medicare-covered x-rays. • \$50 copay for Medicare-covered diagnostic radiology services. • \$0 copay for Medicare-covered therapeutic radiology services. • See page 38 for additional information about diagnostic tests, x-rays, and lab services. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered: <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests. • \$15 copay for Medicare-covered x-rays. • \$50 copay for Medicare-covered diagnostic radiology services. • \$0 copay for Medicare-covered therapeutic radiology services. • See page 38 for additional information about diagnostic tests, x-rays, and lab services.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced	
PREVENTIVE SERVICES					
22.	Bone Mass Measurement (for people with Medicare who are at risk)	<ul style="list-style-type: none"> 20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered bone mass measurement. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered bone mass measurement. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered bone mass measurement.
23.	Colorectal Screening Exams (for people with Medicare age 50 and older)	<ul style="list-style-type: none"> 20% coinsurance. Covered when you are high risk or when you are age 50 and older. 	In-Network <ul style="list-style-type: none"> \$0 copay for: <ul style="list-style-type: none"> Medicare-covered colorectal screenings. Up to 1 additional screening every year. See page 39 for additional information about colorectal screening exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for: <ul style="list-style-type: none"> Medicare-covered colorectal screenings. Up to 1 additional screening every year. See page 39 for additional information about colorectal screening exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for: <ul style="list-style-type: none"> Medicare-covered colorectal screenings. Up to 1 additional screening every year. See page 39 for additional information about colorectal screening exams.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
<p>24. Immunizations (flu vaccine, Hepatitis B vaccine for people with Medicare who are at risk, pneumonia vaccine)</p>	<ul style="list-style-type: none"> • \$0 copay for flu and pneumonia vaccines. • 20% coinsurance for Hepatitis B vaccine. • You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for flu and pneumonia vaccines. • \$0 copay for Hepatitis B vaccine. • No referral needed for flu and pneumonia vaccines. • See page 39 for additional information about immunizations. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for flu and pneumonia vaccines. • \$0 copay for Hepatitis B vaccine. • No referral needed for flu and pneumonia vaccines. • See page 39 for additional information about immunizations. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for flu and pneumonia vaccines. • \$0 copay for Hepatitis B vaccine. • No referral needed for flu and pneumonia vaccines. • See page 39 for additional information about immunizations.
<p>25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<ul style="list-style-type: none"> • 20% coinsurance. • No referral needed. • Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • Medicare-covered screening mammograms. • Up to 1 additional screening mammogram every year. • See page 39 for additional information about mammograms. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • Medicare-covered screening mammograms. • Up to 1 additional screening mammogram every year. • See page 39 for additional information about mammograms. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • Medicare-covered screening mammograms. • Up to 1 additional screening mammogram every year. • See page 39 for additional information about mammograms.

	Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
26.	Pap Smears and Pelvic Exams (for women with Medicare)	<ul style="list-style-type: none"> \$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for pelvic exam. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered Pap smears and pelvic exams. Up to 1 additional Pap smear and pelvic exam every year. See page 39 for additional information about Pap smears and pelvic exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered Pap smears and pelvic exams. Up to 1 additional Pap smear and pelvic exam every year. See page 39 for additional information about Pap smears and pelvic exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered Pap smears and pelvic exams. Up to 1 additional Pap smear and pelvic exam every year. See page 39 for additional information about Pap smears and pelvic exams.
27.	Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<ul style="list-style-type: none"> 20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered prostate cancer screening. Up to 1 additional screening every year. See page 39 for additional information about prostate cancer screening exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered prostate cancer screening. Up to 1 additional screening every year. See page 39 for additional information about prostate cancer screening exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for Medicare-covered prostate cancer screening. Up to 1 additional screening every year. See page 39 for additional information about prostate cancer screening exams.

	Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
28.	End-Stage Renal Disease	<ul style="list-style-type: none"> • 20% coinsurance for renal dialysis. • 20% coinsurance for nutrition therapy for end-stage renal disease. • Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. 	In-Network <ul style="list-style-type: none"> • \$0 copay for renal dialysis. • \$0 copay for nutrition therapy for end-stage renal disease. 	In-Network <ul style="list-style-type: none"> • \$0 copay for renal dialysis. • \$0 copay for nutrition therapy for end-stage renal disease. 	In-Network <ul style="list-style-type: none"> • \$0 copay for renal dialysis. • \$0 copay for nutrition therapy for end-stage renal disease.

	Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
29.	Prescription Drugs	<ul style="list-style-type: none"> Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. 	<p>Drugs covered under Medicare Part B</p> <p>General</p> <ul style="list-style-type: none"> Most drugs not covered. \$32 to \$96 copay for Part B covered drugs (not including Part B covered chemotherapy drugs). \$32 to \$96 copay for Part B covered chemotherapy drugs. <p>Drugs covered under Medicare Part D</p> <p>General</p> <ul style="list-style-type: none"> This plan does not offer prescription drug coverage. 	<p>Drugs covered under Medicare Part B</p> <p>General</p> <ul style="list-style-type: none"> \$32 to \$96 copay for Part B covered drugs (not including Part B covered chemotherapy drugs). \$32 to \$96 copay for Part B covered chemotherapy drugs. <p>Drugs covered under Medicare Part D</p> <p>General</p> <ul style="list-style-type: none"> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.upmchealthplan.com/plan/medicare/pharmacy_index.html on the Web. Different out-of-pocket costs may apply for people who: <ul style="list-style-type: none"> have limited incomes, live in long-term care facilities, or 	<p>Drugs covered under Medicare Part B</p> <p>General</p> <ul style="list-style-type: none"> \$25 to \$75 copay for Part B covered drugs (not including Part B covered chemotherapy drugs). \$25 to \$75 copay for Part B covered chemotherapy drugs. <p>Drugs covered under Medicare Part D</p> <p>General</p> <ul style="list-style-type: none"> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.upmchealthplan.com/plan/medicare/pharmacy_index.html on the Web. Different out-of-pocket costs may apply for people who: <ul style="list-style-type: none"> have limited incomes, live in long-term care facilities, or

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). • The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel). • Total yearly drug costs are the total drug costs paid by both you and the plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from UPMC <i>for Life</i> HMO Rx for certain drugs. 	<ul style="list-style-type: none"> • have access to Indian/Tribal/Urban (Indian Health Service). • The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel). • Total yearly drug costs are the total drug costs paid by both you and the plan. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from UPMC <i>for Life</i> HMO Rx Enhanced for certain drugs.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<ul style="list-style-type: none"> • The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on medicare.gov. • If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. 	<ul style="list-style-type: none"> • The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on medicare.gov. • If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<ul style="list-style-type: none"> • You may have to pay more than your normal cost-sharing amount if you choose to use a higher cost drug when a lower cost drug is available. This may also occur if a new, lower cost generic version of a brand-name drug is added to the plan's formulary after you enroll. • See pages 41 and 42 for additional information about prescription drugs. <hr/> <p>In-Network</p> <ul style="list-style-type: none"> • \$0 deductible. <hr/> <p>Initial Coverage</p> <ul style="list-style-type: none"> • You pay the following until total yearly drug costs reach \$2,700: <p>Retail Pharmacy</p> <p>Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier. 	<ul style="list-style-type: none"> • You may have to pay more than your normal cost-sharing amount if you choose to use a higher cost drug when a lower cost drug is available. This may also occur if a new, lower cost generic version of a brand-name drug is added to the plan's formulary after you enroll. • See pages 41 and 42 for additional information about prescription drugs. <hr/> <p>In-Network</p> <ul style="list-style-type: none"> • \$0 deductible. <hr/> <p>Initial Coverage</p> <ul style="list-style-type: none"> • You pay the following until total yearly drug costs reach \$2,700: <p>Retail Pharmacy</p> <p>Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<ul style="list-style-type: none"> • \$15 copay for a three-month (90-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$32 copay for a one-month (31-day) supply of drugs in this tier. • \$96 copay for a three-month (90-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$80 copay for a one-month (31-day) supply of drugs in this tier. • \$240 copay for a three-month (90-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Long-Term Care Pharmacy Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier. 	<ul style="list-style-type: none"> • \$15 copay for a three-month (90-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs in this tier. • \$75 copay for a three-month (90-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs in this tier. • \$225 copay for a three-month (90-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Long-Term Care Pharmacy Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<p>Preferred Brand</p> <ul style="list-style-type: none"> • \$32 copay for a one-month (31-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$80 copay for a one-month (31-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Mail-Order</p> <p>Generic</p> <ul style="list-style-type: none"> • \$12.50 copay for a three-month (90-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$80 copay for a three-month (90-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$200 copay for a three-month (90-day) supply of drugs in this tier. 	<p>Preferred Brand</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Mail-Order</p> <p>Generic</p> <ul style="list-style-type: none"> • \$12.50 copay for a three-month (90-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$62.50 copay for a three-month (90-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$187.50 copay for a three-month (90-day) supply of drugs in this tier.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<p>Specialty</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Coverage Gap</p> <ul style="list-style-type: none"> After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350. <p>Catastrophic Coverage</p> <ul style="list-style-type: none"> After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or 5% coinsurance. 	<p>Specialty</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Coverage Gap</p> <ul style="list-style-type: none"> After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350. <p>Catastrophic Coverage</p> <ul style="list-style-type: none"> After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of: <ul style="list-style-type: none"> A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or 5% coinsurance.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<p>Out-of-Network</p> <ul style="list-style-type: none"> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from UPMC <i>for Life</i> HMO Rx. <hr/> <p>Out-of-Network Initial Coverage</p> <ul style="list-style-type: none"> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700: 	<p>Out-of-Network</p> <ul style="list-style-type: none"> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from UPMC <i>for Life</i> HMO Rx Enhanced. <hr/> <p>Out-of-Network Initial Coverage</p> <ul style="list-style-type: none"> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<p>Out-of-Network Pharmacy Generic</p> <ul style="list-style-type: none"> \$5 copay for a one-month (31-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> \$32 copay for a one-month (31-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> \$80 copay for a one-month (31-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Out-of-Network Coverage Gap</p> <ul style="list-style-type: none"> After your total yearly drugs costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not 	<p>Out-of-Network Pharmacy Generic</p> <ul style="list-style-type: none"> \$5 copay for a one-month (31-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> \$25 copay for a one-month (31-day) supply of drugs in this tier. <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> \$75 copay for a one-month (31-day) supply of drugs in this tier. <p>Specialty</p> <ul style="list-style-type: none"> 33% coinsurance for a one-month (31-day) supply of drugs in this tier. <hr/> <p>Out-of-Network Coverage Gap</p> <ul style="list-style-type: none"> After your total yearly drugs costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
Prescription Drugs (continued)			<p>be reimbursed by UPMC <i>for Life</i> HMO Rx for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to UPMC <i>for Life</i> HMO Rx so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage</p> <ul style="list-style-type: none"> • After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or • 5% coinsurance. 	<p>be reimbursed by UPMC <i>for Life</i> HMO Rx Enhanced for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to UPMC <i>for Life</i> HMO Rx Enhanced so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage</p> <ul style="list-style-type: none"> • After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> • A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or • 5% coinsurance.

Benefit Category		Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
30.	Dental Services	<ul style="list-style-type: none"> Preventive dental services (such as cleaning) not covered. 	<p>In-Network</p> <ul style="list-style-type: none"> In general, preventive dental benefits (such as cleaning) not covered. \$30 copay for Medicare-covered dental benefits. 	<p>In-Network</p> <ul style="list-style-type: none"> In general, preventive dental benefits (such as cleaning) not covered. \$30 copay for Medicare-covered dental benefits. 	<p>In-Network</p> <ul style="list-style-type: none"> In general, preventive dental benefits (such as cleaning) not covered. \$25 copay for Medicare-covered dental benefits.
31.	Hearing Services	<ul style="list-style-type: none"> Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. 	<p>In-Network</p> <ul style="list-style-type: none"> In general, routine hearing exams and hearing aid(s) not covered. \$30 copay for Medicare-covered diagnostic hearing exams. 	<p>In-Network</p> <ul style="list-style-type: none"> \$0 copay for up to 1 hearing aid(s) every three years. \$30 copay for Medicare-covered diagnostic hearing exams. \$30 copay for up to 1 routine hearing test every year. \$30 copay for up to 1 hearing aid fitting evaluation every three years. \$400 limit for hearing aid(s) every three years. See page 39 for additional information about hearing services. 	<p>In-Network</p> <ul style="list-style-type: none"> \$0 copay for up to 1 hearing aid(s) every three years. \$25 copay for Medicare-covered diagnostic hearing exams. \$25 copay for up to 1 routine hearing test every year. \$25 copay for up to 1 hearing aid fitting evaluation every three years. \$1,000 limit for hearing aid(s) every three years. See page 39 for additional information about hearing services.

	Benefit Category	Original Medicare	UPMC for Life HMO	UPMC for Life HMO Rx	UPMC for Life HMO Rx Enhanced
32.	Vision Services	<ul style="list-style-type: none"> • 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. • Routine eye exams and glasses not covered. • Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. • Annual glaucoma screenings covered for people at risk. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after cataract surgery. • Up to 1 pair(s) of glasses every two years. • Up to 1 pair(s) of contacts every two years. • \$30 copay for exams to diagnose and treat diseases and conditions of the eye. • \$0 copay for up to 1 routine eye exam every two years. • \$200 limit for eye exam and eyewear every two years. • See page 40 for additional information about vision services. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after cataract surgery. • Up to 1 pair(s) of glasses every two years. • Up to 1 pair(s) of contacts every two years. • \$30 copay for exams to diagnose and treat diseases and conditions of the eye. • \$0 copay for up to 1 routine eye exam every two years. • \$200 limit for eye exam and eyewear every two years. • See page 40 for additional information about vision services. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for: <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after cataract surgery. • Up to 1 pair(s) of glasses every two years. • Up to 1 pair(s) of contacts every two years. • \$25 copay for exams to diagnose and treat diseases and conditions of the eye. • \$0 copay for up to 1 routine eye exam every two years. • \$250 limit for eye exam and eyewear every two years. • See page 40 for additional information about vision services.

Benefit Category	Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
33. Physical Exams	<ul style="list-style-type: none"> 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests. 	In-Network <ul style="list-style-type: none"> \$15 copay for routine exams. Limited to 1 exam every year. \$15 copay for Medicare-covered benefits. See page 40 for additional information on physical exams. 	In-Network <ul style="list-style-type: none"> \$15 copay for routine exams. Limited to 1 exam every year. \$15 copay for Medicare-covered benefits. See page 40 for additional information on physical exams. 	In-Network <ul style="list-style-type: none"> \$0 copay for routine exams. Limited to 1 exam every year. See page 40 for additional information on physical exams.
34. Health/Wellness Education	<ul style="list-style-type: none"> Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies. 	In-Network <ul style="list-style-type: none"> This plan covers the following health/wellness education benefits: <ul style="list-style-type: none"> Written health education materials, including newsletters. Health club membership/fitness classes. Nursing hotline. See page 40 for additional information on health/wellness education. 	In-Network <ul style="list-style-type: none"> This plan covers the following health/wellness education benefits: <ul style="list-style-type: none"> Written health education materials, including newsletters. Health club membership/fitness classes. Nursing hotline. See page 40 for additional information on health/wellness education. 	In-Network <ul style="list-style-type: none"> This plan covers the following health/wellness education benefits: <ul style="list-style-type: none"> Written health education materials, including newsletters. Health club membership/fitness classes. Nursing hotline. See page 40 for additional information on health/wellness education.

Benefit Category		Original Medicare	UPMC <i>for Life</i> HMO	UPMC <i>for Life</i> HMO Rx	UPMC <i>for Life</i> HMO Rx Enhanced
35.	Transportation (Routine)	<ul style="list-style-type: none"> Not covered. 	In-Network <ul style="list-style-type: none"> This plan does not cover routine transportation. 	In-Network <ul style="list-style-type: none"> This plan does not cover routine transportation. 	In-Network <ul style="list-style-type: none"> This plan does not cover routine transportation.
36.	Acupuncture	<ul style="list-style-type: none"> Not covered. 	In-Network <ul style="list-style-type: none"> This plan does not cover acupuncture. 	In-Network <ul style="list-style-type: none"> This plan does not cover acupuncture. 	In-Network <ul style="list-style-type: none"> This plan does not cover acupuncture.

Special Features: UPMC *for Life* HMO Plans

The next several pages provide additional information on the medical services described in Section 2 of the Summary of Benefits. UPMC *for Life* encourages you to review this information so you can take advantage of the many benefits and services we provide.

What UPMC *for Life* medical services require prior authorization?

Except in an emergency, you or your doctor must obtain a prior authorization (approval in advance) from UPMC *for Life* before you receive certain services. Failure to get an authorization could result in significantly higher costs to you.

Please call UPMC *for Life* at 1-877-539-3080, seven days a week from 8 a.m. to 8 p.m.. TTY/TDD users should call 1-800-361-2629.

The following medical services require prior authorization:

Benefit Category	Page #
Inpatient Hospital Care	7
Skilled Nursing Facility Care	10
Transplants	n/a
Durable Medical Equipment – only select DME equipment	16

To prior authorize mental health or substance abuse services, you or your doctor must call UPMC Health Plan

Behavioral Health Services at 1-888-251-0083. TTY/TDD users should call 1-877-877-3580, Monday through Friday from 8 a.m. to 5:30 p.m. and Saturday from 8 a.m. to noon. All behavioral health telephone representatives are specially trained and all calls are kept confidential. The following mental health/substance abuse services require prior authorization:

Benefit Category	Page #
Inpatient Mental Health Care	9
Inpatient Substance Abuse Care	7

2009 UPMC *for Life* HMO Plans - Medical Benefits

Benefit Category	UPMC <i>for Life</i> HMO Plan and UPMC <i>for Life</i> HMO Rx Plan	UPMC <i>for Life</i> HMO Rx Enhanced Plan	Page #
Annual Out-of-Pocket Limit	<ul style="list-style-type: none"> You have added protection in UPMC <i>for Life</i> plans with an annual out-of-pocket limit on copays and coinsurance for covered medical expenses. That means, in a single year, you'll never pay more than \$3,100 of your own money for Medicare-covered medical services (Part D drugs, routine hearing and routine vision services are excluded). 	<ul style="list-style-type: none"> You have added protection in UPMC <i>for Life</i> plans with an annual out-of-pocket limit on copays and coinsurance for covered medical expenses. That means, in a single year, you'll never pay more than \$3,100 of your own money for Medicare-covered medical services (Part D drugs, routine hearing and routine vision services are excluded). 	5
Inpatient Hospital Care and Inpatient Mental Health Care	<ul style="list-style-type: none"> \$250 copay per admission up to an out-of-pocket maximum of \$750 per year; then you pay \$0 copay for additional stays. This maximum is a combined limit for inpatient hospital and inpatient mental health care. 	<ul style="list-style-type: none"> \$100 copay per admission up to an out-of-pocket maximum of \$200 per year; then you pay \$0 copay for additional stays. This maximum is a combined limit for inpatient hospital and inpatient mental health care. 	7-9

Benefit Category	UPMC <i>for Life</i> HMO Plan and UPMC <i>for Life</i> HMO Rx Plan	UPMC <i>for Life</i> HMO Rx Enhanced Plan	Page #
Skilled Nursing Facility (SNF)	<ul style="list-style-type: none"> • SNF stays have the following copays: <ul style="list-style-type: none"> • \$0 copay per day for days 1-15 • \$60 copay per day for days 16-65 • \$0 copay per day for days 66-100 • You pay a maximum out-of-pocket cost per year of \$3,000 for skilled nursing facility care. 	<ul style="list-style-type: none"> • SNF stays have the following copays: <ul style="list-style-type: none"> • \$0 copay per day for days 1-15 • \$60 copay per day for days 16-50 • \$0 copay per day for days 51-100 • You pay a maximum out-of-pocket cost per year of \$2,100 for skilled nursing facility care. 	10
Outpatient Services/Surgery	<ul style="list-style-type: none"> • \$150 copay per visit up to an out-of-pocket maximum of \$300 per year; then you pay \$0 copay for additional services. This maximum is a combined limit for all outpatient hospital and ambulatory surgical centers. 	<ul style="list-style-type: none"> • \$60 copay per visit up to an out-of-pocket maximum of \$120 per year; then you pay \$0 copay for additional services. This maximum is a combined limit for all outpatient hospital and ambulatory surgical centers. 	14
Durable Medical Equipment (DME)	<ul style="list-style-type: none"> • Oxygen and oxygen equipment is covered at 100% when supplied by plan providers. • 20% coinsurance applies to all other DME. 	<ul style="list-style-type: none"> • Oxygen and oxygen equipment is covered at 100% when supplied by plan providers. • 20% coinsurance applies to all other DME. 	16
Diabetes Self - Monitoring Training, Nutrition Therapy, and Supplies	<ul style="list-style-type: none"> • 31-day supply: \$20 copay for test strips and only an additional \$10 copay for lancets. • 90-day (retail) supply: \$60 copay for test strips and only an additional \$30 copay for lancets. • 90-day (mail-order) supply: \$50 copay for test strips and only an additional \$25 copay for lancets. Mail order must be purchased through Express Scripts, Inc. 	<ul style="list-style-type: none"> • 31-day supply: \$15 copay for test strips and only an additional \$10 copay for lancets. • 90-day (retail) supply: \$45 copay for test strips and only an additional \$30 copay for lancets. • 90-day (mail-order) supply: \$37.50 copay for test strips and only an additional \$25 copay for lancets. Mail order must be purchased through Express Scripts, Inc. 	17
Diagnostic Tests, X-Rays, and Lab Services	<ul style="list-style-type: none"> • \$0 copay for lab services, diagnostic lab tests, and therapeutic radiology (e.g., radiation). • \$15 copay for general x-rays. • \$50 copay for: MRI, MRA, CT Scans, PET Scans, Nuclear Medicine, and Stress Tests. 	<ul style="list-style-type: none"> • \$0 copay for lab services, diagnostic lab tests, and therapeutic radiology (e.g., radiation). • \$15 copay for general x-rays. • \$50 copay for advanced imaging such as MRI, MRA, CT Scans, PET Scans, Nuclear Medicine, and Stress Tests. • You pay a \$200 annual maximum for x-rays and advanced imaging services. 	18

Benefit Category	UPMC <i>for Life</i> HMO Plan and UPMC <i>for Life</i> HMO Rx Plan	UPMC <i>for Life</i> HMO Rx Enhanced Plan	Page #
Screening Exams: Colorectal Screening Exams, Mammograms, Pap Smears and Pelvic Exams, Prostate Cancer Screening Exams	<ul style="list-style-type: none"> Screening exams have \$0 copay for the Medicare-covered exam. UPMC <i>for Life</i> also allows one additional routine screening exam, beyond the one that Medicare allows, with no additional copay. (Note: If your physician orders additional exams, these are covered as medical exams not routine.) 	<ul style="list-style-type: none"> Screening exams have \$0 copay for the Medicare-covered exam. UPMC <i>for Life</i> also allows one additional routine screening exam, beyond the one that Medicare allows, with no additional copay. (Note: If your physician orders additional exams, these are covered as medical exams not routine.) 	19-21
Immunizations	<ul style="list-style-type: none"> \$0 copay for flu, pneumonia, and Hepatitis B vaccines. HMO Rx Plan <ul style="list-style-type: none"> Other vaccines and their administration fees, such as the Zoster (shingles) vaccine, are covered under your Part D prescription drug coverage. HMO Plan (only) <ul style="list-style-type: none"> No coverage for other Part D vaccines or their administration fees. 	<ul style="list-style-type: none"> \$0 copay for flu, pneumonia, and Hepatitis B vaccines. Other vaccines and their administration fees, such as the Zoster (shingles) vaccine, are covered under your Part D prescription drug coverage. 	20
Drugs Covered Under Part B	<ul style="list-style-type: none"> \$32 copay for a 31-day supply of Part B drugs purchased at a pharmacy. \$96 copay for a 90-day (retail) supply of Part B drugs purchased at a pharmacy. \$80 copay for a 90-day (mail-order) supply of Part B drugs. Mail-order must be purchased through Express Scripts, Inc. 	<ul style="list-style-type: none"> \$25 copay for a 31-day supply of Part B drugs purchased at a pharmacy. \$75 copay for a 90-day (retail) supply of Part B drugs purchased at a pharmacy. \$62.50 copay for a 90-day (mail-order) supply of Part B drugs. Mail-order must be purchased through Express Scripts, Inc. 	23
Hearing Services	HMO Rx Plan <ul style="list-style-type: none"> \$30 copay for one routine hearing test every year. \$30 copay for one hearing aid fitting and evaluation every three years. \$400 toward the cost of a hearing aid(s) every three years (cannot exceed cost of the hearing aid). HMO Plan (only) <ul style="list-style-type: none"> No coverage for routine hearing exams or aids. 	<ul style="list-style-type: none"> \$25 copay for one routine hearing test every year. \$25 copay for one hearing aid fitting and evaluation every three years. \$1,000 toward the cost of a hearing aid(s) every three years (cannot exceed cost of the hearing aid). 	33

Benefit Category	UPMC <i>for Life</i> HMO Plan and UPMC <i>for Life</i> HMO Rx Plan	UPMC <i>for Life</i> HMO Rx Enhanced Plan	Page #
Vision Services	<ul style="list-style-type: none"> • \$200 toward the cost of one routine eye exam and eyewear every two years. This \$200 allowance can be used for routine eye services from plan providers or non-plan providers. (NOTE: You may have to pay out-of-pocket then submit the claim for payment of services provided by non-plan providers.) • Routine eyewear includes the lenses and one pair of eyeglass frames or contact lenses (includes contact lens fitting exam) every two years. • Eyewear does not include lens options, such as tints, progressives, polish, and insurance. • You can contact OptiCare at 1-866-921-7963 to see if your vision provider is in our network. TTY/TDD users call 1-800-361-2629. 	<ul style="list-style-type: none"> • \$250 toward the cost of one routine eye exam and eyewear every two years. This \$250 allowance can be used for routine eye services from plan providers or non-plan providers. (NOTE: You may have to pay out-of-pocket then submit the claim for payment of services provided by non-plan providers.) • Routine eyewear includes the lenses and one pair of eyeglass frames or contact lenses (includes contact lens fitting exam) every two years. • Eyewear does not include lens options, such as tints, progressives, polish, and insurance. • You can contact OptiCare at 1-866-921-7963 to see if your vision provider is in our network. TTY/TDD users call 1-800-361-2629. 	34
Physical Exams	<ul style="list-style-type: none"> • \$15 copay for routine physical exam. Routine exam must be performed by your PCP. • You are entitled to 1 routine exam per year, plus the “Welcome to Medicare” exam during your first 12 months of Part B coverage. 	<ul style="list-style-type: none"> • \$0 copay for routine physical exam. Routine exam must be performed by your PCP. • You are entitled to 1 routine exam per year, plus the “Welcome to Medicare” exam during your first 12 months of Part B coverage. 	35
Health/Wellness Education	<ul style="list-style-type: none"> • \$0 copay for membership at participating Silver&Fit™ network fitness clubs. Please refer to the separate brochure enclosed with this packet. • UPMC <i>for Life</i> offers a 24/7 nurse advice line available at 1-866-918-1591. TTY/TDD users call 1-866-918-1593. 	<ul style="list-style-type: none"> • \$0 copay for membership at participating Silver&Fit™ network fitness clubs. Please refer to the separate brochure enclosed with this packet. • UPMC <i>for Life</i> offers a 24/7 nurse advice line available at 1-866-918-1591. TTY/TDD users call 1-866-918-1593. 	35
Worldwide Emergency Service	<ul style="list-style-type: none"> • UPMC <i>for Life</i> provides worldwide emergency travel services through Assist America. • Please refer to the separate brochure enclosed with this packet. 	<ul style="list-style-type: none"> • UPMC <i>for Life</i> provides worldwide emergency travel services through Assist America. • Please refer to the separate brochure enclosed with this packet. 	n/a

Outline of Prescription Drug Coverage with UPMC for Life HMO Rx Plan and HMO Rx Enhanced Plan

The following chart summarizes your UPMC for Life prescription drug coverage. This chart does not apply to UPMC for Life HMO Plan.

Benefit:	UPMC for Life HMO Rx Plan	UPMC for Life HMO Rx Enhanced Plan
Deductible	\$0 deductible	\$0 deductible
31-Day Supply - In-Network Retail Pharmacy		
Generic drugs (Tier 1)	\$5 copay up to a 31-day supply	\$5 copay up to a 31-day supply
Preferred brand drugs (Tier 2)	\$32 copay up to a 31-day supply	\$25 copay up to a 31-day supply
Non-preferred brand drugs (Tier 3)	\$80 copay up to a 31-day supply	\$75 copay up to a 31-day supply
Specialty drugs (Tier 4)	33% coinsurance up to a 31-day supply	33% coinsurance up to a 31-day supply
90-Day Supply - In-Network Retail Pharmacy		
Generic drugs (Tier 1)	\$15 copay up to a 90-day supply	\$15 copay up to a 90-day supply
Preferred brand drugs (Tier 2)	\$96 copay up to a 90-day supply	\$75 copay up to a 90-day supply
Non-preferred brand drugs (Tier 3)	\$240 copay up to a 90-day supply	\$225 copay up to a 90-day supply
Specialty drugs (Tier 4)	33% coinsurance up to a 31-day supply	33% coinsurance up to a 31-day supply
90-Day Supply - In-Network Mail-Order Pharmacy		
Generic drugs (Tier 1)	\$12.50 copay up to a 90-day supply	\$12.50 copay up to a 90-day supply
Preferred brand drugs (Tier 2)	\$80 copay up to a 90-day supply	\$62.50 copay up to a 90-day supply
Non-preferred brand drugs (Tier 3)	\$200 copay up to a 90-day supply	\$187.50 copay up to a 90-day supply
Specialty drugs (Tier 4)	33% coinsurance up to a 31-day supply	33% coinsurance up to a 31-day supply
31-Day Supply – Long-Term Care Pharmacy or Out-of-Network Pharmacy		
Generic drugs (Tier 1)	\$5 copay up to a 31-day supply	\$5 copay up to a 31-day supply
Preferred brand drugs (Tier 2)	\$32 copay up to a 31-day supply	\$25 copay up to a 31-day supply
Non-preferred brand drugs (Tier 3)	\$80 copay up to a 31-day supply	\$75 copay up to a 31-day supply
Specialty drugs (Tier 4)	33% coinsurance up to a 31-day supply	33% coinsurance up to a 31-day supply
Note: You will pay more than just a copay at an out-of-network pharmacy. You are responsible for the difference between the UPMC for Life allowed amount and the pharmacy charge for the prescription drug. Contact the plan for details.		
Prescription Drug Initial Coverage Limit	\$2,700 <ul style="list-style-type: none"> • When your total prescription drug costs paid by you and UPMC for Life reach \$2,700, you will pay 100% of your drug costs until you reach your drug out-of-pocket maximum for the year. 	\$2,700 <ul style="list-style-type: none"> • When your total prescription drug costs paid by you and UPMC for Life reach \$2,700, you will pay 100% of your drug costs until you reach your drug out-of-pocket maximum for the year.
Drug Coverage Through the Coverage Gap	No coverage in the coverage gap.	No coverage in the coverage gap.

Benefit:	UPMC <i>for Life</i> HMO Rx Plan	UPMC <i>for Life</i> HMO Rx Enhanced Plan						
Prescription Drug Out-of-Pocket Limit <ul style="list-style-type: none"> This may also be referred to as your TrOOP (True Out-of-Pocket) amount. 	\$4,350 - Your out-of-pocket limit includes: <ul style="list-style-type: none"> Your copays 100% of your drug costs, after your \$2,700 initial coverage limit is met Out-of-network drug costs 	\$4,350 - Your out-of-pocket limit includes: <ul style="list-style-type: none"> Your copays 100% of your drug costs, after your \$2,700 initial coverage limit is met Out-of-network drug costs 						
Copayments After Your Out-of-Pocket \$4,350 Maximum Is Met	You pay the greater of: <ul style="list-style-type: none"> \$2.40 copay for generics (including brand drugs treated as generics) \$6.00 copay for all other drugs, or 5% coinsurance 	You pay the greater of: <ul style="list-style-type: none"> \$2.40 copay for generics (including brand drugs treated as generics) \$6.00 copay for all other drugs, or 5% coinsurance 						
<p>Over-the-Counter (OTC) Medications: The following drugs are covered by UPMC <i>for Life</i> at 100% when purchased at a network pharmacy. A prescription for the medication is needed from your doctor. The costs of these drugs are not applied to your out-of-pocket limit (TrOOP).</p> <table border="0"> <tr> <td>Over-the-Counter Medication:</td> <td>Dosage:</td> </tr> <tr> <td>Omeprazole OTC (only)</td> <td>20 mg Tablets</td> </tr> <tr> <td>Loratadine OTC (only)</td> <td>10 mg Tablets or Liquid</td> </tr> </table>			Over-the-Counter Medication:	Dosage:	Omeprazole OTC (only)	20 mg Tablets	Loratadine OTC (only)	10 mg Tablets or Liquid
Over-the-Counter Medication:	Dosage:							
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<p>Important Prescription Drug Information:</p> <ol style="list-style-type: none"> Your doctor must call UPMC <i>for Life</i> for prior authorization for certain prescription drugs; please refer to the formulary. Some prescription drugs may have a monthly quantity limit; please refer to the formulary. UPMC <i>for Life</i> may require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition (this is known as Step Therapy). UPMC <i>for Life</i> will not pay for non-formulary drugs, except under certain clinical exceptions. Contact the plan for details. If the actual cost of a prescription drug is less than the copay amount for the drug, you will pay the actual cost, not the copay amount. If you choose a brand-name prescription drug whenever a generic drug equivalent exists, you will have to pay the drug tier copayment (e.g., Tier 2-3) and the difference in cost between the generic drug and the brand-name prescription drug. Drugs covered under Medicare Part B do not count toward your Part D out-of-pocket limit. 								
<p>Out-of-Network Retail Pharmacy Information:</p> <ul style="list-style-type: none"> If you use an out-of-network pharmacy, you must pay the full cost of the prescription, at the point of sale. Out-of-network drug claims must be submitted to UPMC <i>for Life</i>, so the amount can be added to your annual out-of-pocket total. You will need to submit a paper claim to Express Scripts, Inc., Attn: Med D Accounts, P.O. Box 66752, St. Louis, MO 63166-6752 for payment. Contact the plan for details. 								

UPMC *for Life*

UPMC Health Plan Medicare Program

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