



2012 **SUMMARY OF BENEFITS**

UPMC for Life
Options (HMO SNP)

UPMC Health Plan Medicare Program

Pennsylvania H3907

H3907_12_159 CMS Approved 09/29/2011

**Section I: Introduction to the Summary of Benefits
For UPMC *for Life* Options (HMO SNP)
January 1, 2012 - December 31, 2012
Western Pennsylvania**

Thank you for your interest in UPMC *for Life* Options (HMO SNP). Our plan is offered by University of Pittsburgh Medical Center/UPMC Health Plan, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

If you reside in a nursing home or you are living in the community but require the same level of care as someone in a nursing home, you may be eligible to join this plan.

Please call UPMC *for Life* Options (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call UPMC *for Life* Options (HMO SNP) 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* Options (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are living in a nursing home or you live in the community or in an assisted living facility and require the same level of care as someone in a nursing home, you may join or leave a plan at any time.

Please call UPMC *for Life* Options (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD 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* Options (HMO SNP) 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* Options (HMO SNP) AVAILABLE?

The service area for this plan includes: Allegheny County, PA. You must live in this area to join the plan.

WHO IS ELIGIBLE TO JOIN UPMC *for Life* Options (HMO SNP)?

You can join UPMC *for Life* Options (HMO SNP) 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 generally are not eligible to enroll in UPMC *for Life* Options (HMO SNP) unless they are members of our organization and have been since their dialysis began.

If you are a resident of a nursing home you may be eligible to join the plan or if you reside or agree to reside in a nursing home that has a contract with the health plan.

You must live in one of the following facilities to join this plan:

Canterbury Place	310 Fisk Street, Pittsburgh, PA 15201
Heritage	5701 Phillips Avenue, Pittsburgh, PA 15217
Seneca Place	5360 Saltsburg Road, Verona, PA 15147

Or

You must require the same amount of care as someone in a nursing home but reside in your home or another community residence to join this plan.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

UPMC *for Life* Options (HMO SNP) has 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. For an updated list, visit us at: <http://www.upmchealthplan.com/snp>.

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 except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

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

UPMC *for Life* Options (HMO SNP) has 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/medicare/partd.html>.

Our customer service number is listed at the end of this introduction.

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

UPMC *for Life* Options (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

UPMC *for Life* Options (HMO SNP) uses 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/medicare/partd.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 OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/ 7 days a week, and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday TTY/TDD users should call 1-800-325-0778; or
- Your state Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, 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* Options (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or

appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of UPMC *for Life* Options (HMO SNP), 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. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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* Options (HMO SNP) 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* Options (HMO SNP) 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 alfa 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.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call UPMC Health Plan for more information about UPMC *for Life* Options (HMO SNP).
Visit us at <http://www.upmchealthplan.com/snp> 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 **1-800-606-8648** for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Program.
(TTY/TDD: **1-866-407-8762**.)

Prospective members should call toll-free **1-866-405-8762** for questions related to the Medicare Advantage program and Medicare Part D Prescription Drug Program.
(TTY/TDD: **1-866-407-8762**.)

Current members should call locally **1-800-606-8648** for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Program.
(TTY/TDD: **1-866-407-8762**.)

Prospective members should call locally **1-866-405-8762** for questions related to the Medicare Advantage program and Medicare Part D Prescription Drug Program.
(TTY/TDD: **1-866-407-8762**.)

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.

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

SUMMARY OF BENEFITS
UPMC for Life Options (HMO SNP)

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

SECTION II: SUMMARY OF BENEFITS		
Benefit Category	Original Medicare	UPMC for Life Options (HMO SNP)
IMPORTANT INFORMATION		
1-Premium and Other Important Information	<p>In 2012 the monthly Part B premium is \$99.90 and the annual Part B deductible amount is \$140.00.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General</p> <p>\$31.50 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>In 2012 the annual Part B deductible amount is \$140.00.</p> <p>Contact the plan for services that apply.</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
1-Premium and Other Important Information (continued)		\$6,700 out-of-pocket limit for Medicare-covered services.
2-Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.
INPATIENT CARE		
3-Inpatient Hospital Care (Includes substance abuse and rehabilitation services)	<p>In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156.00 deductible Days 61 - 90: \$289.00 per day Days 91 - 150: \$578.00 per lifetime reserve day.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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.</p>	<p>In-Network Plan covers 90 days each benefit period.</p> <p>In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156.00 deductible Days 61 - 90: \$289.00 per day Days 91 - 150: \$578.00 per lifetime reserve day.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
4-Inpatient Mental Health Care	<p>In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156.00 deductible Days 61 - 90: \$289.00 per day Days 91 - 150: \$578.00 per</p>	<p>In-Network In 2012 the amounts for each benefit period are: Days 1 - 60: \$1156.00 deductible Days 61 - 90: \$289.00 per day</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
<p>4-Inpatient Mental Health Care (continued)</p>	<p>lifetime reserve day.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>Days 91 - 150: \$578.00 per lifetime reserve day.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>5-Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 per day Days 21 - 100: \$144.50 per day.</p> <p>100 days for each benefit period.</p> <p>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>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 per day Days 21 - 100: \$144.50 per day.</p> <p>You will not be charged additional cost sharing for professional services</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
6-Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	In-Network <ul style="list-style-type: none"> • \$0 copay for Medicare-covered home health visits.*
7-Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE		
8-Doctor Office Visits	20% coinsurance	In-Network <ul style="list-style-type: none"> • 20% of the cost for each primary care doctor visit for Medicare-covered benefits. • 20% of the cost for each in-area, network urgent care Medicare-covered visit. • 20% of the cost for each specialist visit for Medicare-covered benefits.
9-Chiropractic Services	Supplemental 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 providers.	General Authorization rules may apply. In-Network <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a subluxation (a displacement or misalignment of a joint or body part) if you get it

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
9-Chiropractic Services (continued)		from a chiropractor or other qualified providers.
10-Podiatry Services	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network</p> <ul style="list-style-type: none"> • 20% of the cost for each Medicare-covered visit. <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p>
11-Outpatient Mental Health Care	<p>40% coinsurance for most outpatient mental health services.</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> • 40% of the cost for each Medicare-covered individual therapy visit with a psychiatrist. • 40% of the cost for each Medicare-covered group therapy visit with a psychiatrist. • 20% of the cost for Medicare-covered partial hospitalization program services.
12-Outpatient Substance Abuse Care	20% coinsurance	<p>In-Network</p> <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered individual visits. • 20% of the cost for Medicare-covered group visits.
13-Outpatient Services/Surgery	<p>20% coinsurance for the doctor’s services.</p> <p>Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible.</p>	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> • 20% of the cost for each Medicare-covered

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
13-Outpatient Services/Surgery (continued)	20% coinsurance for ambulatory surgical center facility services.	ambulatory surgical center visit. <ul style="list-style-type: none"> • 20% of the cost for each Medicare-covered outpatient hospital facility visit.
14-Ambulance Services (medically necessary ambulance services)	20% coinsurance	In Network <ul style="list-style-type: none"> • 20% of the cost for each Medicare-covered ambulance benefits.
15-Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General <ul style="list-style-type: none"> • 20% of the cost (up to \$65) for Medicare-covered emergency room visits. • Worldwide coverage.
16-Urgently Needed Care (This is NOT emergency care, and, in most cases, is out of the service area.)	20% coinsurance or a set copay. NOT covered outside the U.S. except under limited circumstances.	General <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered urgently needed care visits.
17-Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
17-Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy) (continued)		limits. <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered occupational therapy visits. • 20% of the cost for Medicare-covered physical and/or speech and language therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18-Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered items.
19-Prosthetic Devices (Includes braces, artificial limbs, and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered items.
20-Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts	In-Network <ul style="list-style-type: none"> • 20% of the cost for diabetes self-management training. • 20% of the cost for diabetes monitoring supplies. • 20% of the cost for therapeutic shoes or inserts.
21-Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	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	In-Network <ul style="list-style-type: none"> • 0% of the cost for Medicare-covered lab services. • 20% of the cost for

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
21-Diagnostic Tests, X-Rays, Lab Services, and Radiology Services (continued)	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 supplemental routine screening tests, like checking your cholesterol.	Medicare-covered diagnostic procedures and tests. <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered x-rays. • 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays). • 20% of the cost for Medicare-covered therapeutic radiology services.
22-Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for cardiac rehabilitation services 20% coinsurance for pulmonary rehabilitation services 20% coinsurance for intensive cardiac rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	In-Network <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered cardiac rehabilitation Services. • 20% of the cost for Medicare-covered intensive cardiac rehabilitation services. • 20% of the cost for Medicare-covered pulmonary rehabilitation services.
PREVENTIVE SERVICES		
23-Preventive Services and Wellness/Education Programs	No coinsurance, copayment, or deductible for the following: <ul style="list-style-type: none"> - Abdominal aortic aneurysm screening - Bone mass measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions - Cardiovascular screening - Cervical and vaginal cancer screening. Covered once every 2 years. Covered once a year for women with Medicare at 	In-Network \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> - Abdominal aortic aneurysm screening - Bone mass measurement - Cardiovascular screening - Cervical and vaginal cancer screening (Pap test and pelvic exam) - Colorectal cancer screening - Diabetes screening - Influenza vaccine

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
23-Preventive Services and Wellness/Education Programs (continued)	<p>high risk.</p> <ul style="list-style-type: none"> - Colorectal cancer screening - Diabetes screening - Influenza vaccine - Hepatitis B vaccine for people with Medicare who are at risk - HIV screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. - Breast cancer screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. - Medical nutrition therapy services. 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. - Personalized prevention plan services (Annual wellness visit) 	<ul style="list-style-type: none"> - Hepatitis B vaccine - HIV screening - Breast cancer screening (mammogram) - Medical nutrition therapy services - Personalized prevention plan services (Annual Wellness visits) - Pneumococcal vaccine - Prostate cancer screening (Prostate Specific Antigen (PSA) test only) - Smoking cessation (counseling to stop smoking) - Welcome to Medicare Physical Exam (initial preventive physical exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> - Written health education materials, including newsletters - Nursing hotline

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
23-Preventive Services and Wellness/Education Programs (continued)	<ul style="list-style-type: none"> - Pneumococcal vaccine. You may only need the pneumonia vaccine once in your lifetime. - Call your doctor for more information. - Prostate cancer screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. - Smoking cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. - Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	
24-Kidney Disease and Conditions	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	In-Network <ul style="list-style-type: none"> • 20% of the cost for renal dialysis. • 20% of the cost for kidney disease education services.
25-Outpatient Prescription Drugs	<p>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</p>	Drugs Covered under Medicare Part B General <ul style="list-style-type: none"> • 20% of the cost for Part B- covered chemotherapy drugs and other Part B- covered drugs.

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
<p>25-Outpatient Prescription Drugs (continued)</p>	<p>drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs Covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at</p> <p>www.upmchealthplan.com/plan/medicare/partd.html on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or <p>have access to Indian/Tribal/Urban (Indian Health Service) providers</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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).</p> <p>Total yearly drug costs are the total drug costs paid by you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
<p>25-Outpatient Prescription Drugs (continued)</p>		<p>Your provider must get prior authorization from UPMC <i>for Life Options</i> (HMO SNP) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>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.</p> <p>In-Network \$320 annual deductible.</p> <p>Initial Coverage After you pay your yearly deductible, you pay 25% until total yearly drug costs reach \$2,930.</p> <p>Retail Pharmacy You can get drugs the following way(s): <ul style="list-style-type: none"> - one-month (31-day) supply - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy You can get drugs the following</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
<p>25-Outpatient Prescription Drugs (continued)</p>		<p>way(s): - one-month (31-day) supply</p> <p>Mail Order You can get drugs the following way(s): - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan’s costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700,</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of: -5% coinsurance, or -\$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.</p> <p>Out-of-Network 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</p>

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
<p>25-Outpatient Prescription Drugs (continued)</p>		<p>UPMC <i>for Life Options</i> (HMO SNP). You can get drugs the following way: -one-month(31-day) supply</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach \$2,930.</p> <p>Additional Out-of-Network Coverage Gap You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan’s cost of the drug minus your cost share, which is the greater of: -5% coinsurance, or -\$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.</p>
<p>26-Dental Services</p>	<p>Preventive dental services (such as cleanings) not covered.</p>	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for the following preventive

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
26-Dental Services (continued)		dental benefits: <ul style="list-style-type: none"> • up to 1 oral exam every six months • up to 1 cleaning every six months • up to 1 dental x-ray every six months 20% of the cost for Medicare-covered dental benefits.
27-Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network In general, supplemental routine hearing exams and hearing aids not covered. <ul style="list-style-type: none"> • 20% of the cost for Medicare-covered diagnostic hearing exams.
28-Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental 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.	In-Network <ul style="list-style-type: none"> • 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. • 20% of the cost for exams to diagnose and treat diseases and conditions of the eye. • 0% of the cost for up to 1 supplemental routine eye exam every two years. • 0% of the cost for up to 1 pair of glasses every two years. • 0% of the cost for up to 1 pair of contacts every two years. • \$100 plan coverage limit for eye wear every two years.
29-Over-the-Counter items	Not covered.	General The plan does not cover over-the-counter items.
30-Transportation (Routine)	Not covered.	General Authorization rules may apply.

Benefit Category	Original Medicare	UPMC <i>for Life Options</i> (HMO SNP)
30-Transportation (Routine) (continued)		In-Network \$0 copay for up to 24 one-way trip(s) to plan-approved location every year.
31-Acupuncture	Not covered.	In-Network This plan does not cover acupuncture.

Section III: Special Features

UPMC *for Life* Options (HMO SNP)

UPMC *for Life* Options (HMO SNP) is a coordinated care plan with a Medicare Advantage contract. The next few pages provide additional information on some of the medical benefits and services described in Section II of this Summary of Benefits. UPMC *for Life* Options encourages you to review this information so you can take advantage of the many benefits and services designed to keep you healthy.

UPMC *for Life* Options was designed to meet the unique needs of people that require long-term care and that live in a participating apartment or home, or a participating nursing home. UPMC *for Life* Options uses a specialized provider network to provide medical and prescription drug benefits to help you receive care while maintaining comfort and dignity. Services are offered in the setting you choose and are designed to promote constant communication with your care team to give you and your loved ones the peace of mind that you deserve.

You may require **Long-Term Care** if you have difficulty bathing, dressing yourself, or preparing your own meals because of a medical condition. To become eligible, you must have an assessment saying you require long-term care services.

Note: If you are entitled to Medicare Part A and are enrolled in Part B and maintain full Medical Assistance coverage, you will not have to pay out-of-pocket costs for premiums, deductibles, copayments, and coinsurances for medical services. These costs should be covered under your Medicaid benefits. You will be responsible for your prescription drug copayments and your Medicaid copayments, if applicable.

To learn more, call UPMC *for Life* Options at 1-866-405-8762, 8:00 a.m. to 8:00 p.m., seven days a week.* TTY users call 1-866-407-8762. *From February 15 through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 3 p.m. on Saturday.

Health benefits made easy for Medicare Members!

With UPMC *for Life* Options you receive:

A Specialized Network

Our network of primary care doctors, specialists, hospitals, and nursing facilities are uniquely qualified to meet your changing needs. You will have access to University of Pittsburgh Medical Center (UPMC) hospitals, doctors, and facilities best suited to care for you.

A Transportation Benefit

You are covered at 100% for up to 24 one-way trips to plan-approved locations (like your doctor's office) by a participating vendor every year. Get to the right appointment, at the right time, and back to your home hassle-free. Prior authorization may be required.

A Personal Emergency Response System

Members living at home receive a Personal Emergency Response system to maximize your safety and alert someone immediately if you have a fall or become very ill. You and your loved ones can rest easy knowing that someone will be there if you need help. Prior authorization may be required.

Enhanced Skilled Nursing Benefits

You may be admitted to a skilled nursing facility *without* first having a hospital stay. This can potentially save you money on deductible costs that you might have incurred by going to the hospital first.

Emergency Care

You are covered for worldwide emergency care, so that you can get the emergency treatment you need, no matter where you are. See page 12 for more information.

Prescription Drug Coverage

See pages 16 to 20 for more information.

Dental Benefits

You are covered at 100% for routine oral exams, cleanings, and dental x-rays once every six months.

Vision Benefits

You are covered at 100% for routine eye exams up to one visit every two years. You also receive a vision allowance of up to \$100 for 1 pair of eyeglasses or contact lenses every two years.

Preventive Care

You are covered at 100% for services listed on page 14 to 16. Keeping up with your preventive care (like vaccinations and screenings) is important to maintain your health and well-being, and does not require a copay.

Extra Help With Your Health Care

If you have questions about your health, your care, or anything medical you can call our MyHealth Advice Line, a nursing advice line available 24 hours a day, 7 days a week. You can also receive help from our nurses and social workers and our written health education materials, including newsletters, to explain things and help you with your specific condition.

How do I fill a prescription through UPMC *for Life* Options?

Retail Pharmacy

You can fill your prescription at any retail pharmacy that is in our large national pharmacy network, including larger retail chain pharmacies, such as CVS, Giant Eagle, Rite Aid, and Wal-Mart, as well as smaller local independent pharmacies. You can refer to the UPMC *for Life* Options Pharmacy Directory for more information or visit our website at www.upmchealthplan.com/snp. You may be eligible to participate in the 90-day retail pharmacy program. Many retail pharmacies in the UPMC *for Life* Options network can fill a three-month supply of a maintenance drug. A maintenance drug is taken on a regular basis for a chronic or long-term medical condition. Contact your provider to determine if the medication(s) you are currently taking are considered qualifying maintenance drugs so that they can be filled for three months instead of one month. The pharmacy directory lists retail pharmacies that can fill a three-month prescription. **If you receive extra help, your copayment for a three-month prescription filled at a retail pharmacy will be the same amount as what you pay for a one-month supply. You can save two months of copayments.** However, if you do not qualify for extra help, you will be responsible for all three months coinsurance under UPMC *for Life* Options. For more information, contact UPMC *for Life* Options Customer Service. See page 5 for plan contact information.

Mail-Order Pharmacy Service

UPMC *for Life* Options also offers a mail-order pharmacy service. This service is similar to the retail pharmacy service as explained above; but, instead of going to a participating retail pharmacy, you must complete a mail-order form. If you receive extra help, your copayment for a three-month maintenance prescription filled through the mail-order service will be the same amount as what you pay for a one-month supply. However, if you do not qualify for extra help, you will be responsible for all three months coinsurance under UPMC *for Life* Options. To obtain order forms and for more information about filling your prescriptions by mail, contact UPMC *for Life* Options Customer Service. See page 5 for plan contact information.

What types of medical services require prior authorization from UPMC *for Life* Options?

Except in an emergency, you or your physician must obtain prior authorization from UPMC *for Life* Options before you receive any of the services listed below. Failure to get prior authorization could result in your full responsibility to pay for all costs incurred. Please call UPMC *for Life* Options at **1-800-606-8648**, 8 a.m. to 8 p.m., seven days a week. TTY users should call **1-866-407-8762**. From February 15, through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 3 p.m. on Saturday. All telephone representatives are specially trained and all calls are kept confidential.

The following is a list of services that require a prior authorization from UPMC *for Life* Options including, but not limited to:

- Inpatient Hospital Care – see page 8 for benefit information.

- Inpatient Mental Health or Drug and Alcohol Services – prior authorization is required for certain neuropsychological and psychological testing – see pages 8 to 9 for benefit information.
- Skilled Nursing Facility Care or Rehabilitation Facility Care – see page 9 for benefit information.
- Outpatient Surgery and Organ Transplants – prior authorization is required for certain outpatient surgical procedures and all organ transplants – see page 11 and 12 for benefit information.
- Durable Medical Equipment – prior authorization is required for certain equipment such as electric wheelchairs – see page 13 for benefit information.
- Prosthetic Devices – prior authorization is required for certain prosthetic devices – see page 13 for benefit information.
- Out-of-network services (exception out-of-area renal dialysis services, emergency services, out of area urgently needed services).
- Part B drugs – prior authorization is required for certain Part B drugs.

How can I enroll in UPMC *for Life Options*?

Call UPMC *for Life Options* at 1-866-405-8762, 8:00 a.m. to 8:00 p.m., seven days a week to learn more! TTY users should call 1-866-407-8762. From February 15, through October 14, we are available from 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 3 p.m. on Saturday. Please leave a message and your call will be returned the next business day.

To enroll in UPMC *for Life Options*:

- Prior to enrolling in UPMC *for Life Options*, you must meet the criteria for an institutional level of care and will likely require an assessment by an area agency. This is required to complete your enrollment application.
- Send your completed and signed enrollment application to UPMC *for Life Options*, PO Box 2967, Pittsburgh, PA 15230, or you can fax it to 412-454-2973. If you have already received and reviewed UPMC *for Life Options* enrollment materials and would like to enroll over the telephone instead of completing and returning the paper application, please contact UPMC *for Life Options* at the number above. If you would like an application, or for questions about completing the application, or to set up an appointment for a licensed sales representative to come to your home and assist you in completing the application, please contact UPMC *for Life Options* at the number above.

UPMC *for Life Options* has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2014. NCQA's approval is based on a review of UPMC *for Life Options*' Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of UPMC *for Life Options* or the quality of service provided by UPMC *for Life Options*. UPMC *for Life Options* will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 1-800-606-8648.

UPMC *for Life* *Options* (HMO SNP)

To find out if UPMC *for Life* Options
is right for you, call toll-free **1-866-405-8762**
TTY/TDD users should call **1-866-407-8762**

UPMC HEALTH PLAN

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com/snp