

WHAT YOU NEED TO KNOW ABOUT YOUR MEDICARE ADVANTAGE PLAN.

2017 Your Plan Explained

Public Education Employees' Health Insurance Plan (PEEHIP)

UnitedHealthcare® Group Medicare Advantage (PPO)

Effective: January 1, 2017 through December 31, 2017

Group Number: 15500



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Enjoy the benefits of the **UnitedHealthcare® Group Medicare Advantage (PPO) plan sponsored by PEEHIP.**

Look inside this guide to learn more.



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Welcome Medicare-eligible PEEHIP RETIREES

**UnitedHealthcare is just
a phone call away.
1-877-298-2341,
TTY 711, 8 a.m. – 8 p.m.
local time, Monday - Friday**

**Learn more online at
[www.UHCRetiree.com/
peehip](http://www.UHCRetiree.com/peehip)**

UnitedHealthcare and the Public Education Employees' Health Insurance Plan (PEEHIP) have worked closely together to offer a Medicare Advantage plan that includes both medical and prescription drug coverage for all eligible retirees and their eligible dependents. We look forward to providing your health care coverage. In addition, at UnitedHealthcare, we believe you should have more than just a good insurance plan to help maintain your health. We want to work with you to help you live a healthier life.

We want to:

- Help you get access to the care you may need when you need it
- Give you tools and resources to help you be in more control of your health
- Try to help you find ways to save money on health care costs, so you can spend more on the things that matter most to you

Use this guide

As with any transition, there are a few changes in how this plan works compared to your previous PEEHIP hospital, medical and prescription drug plans. To make it easier to understand and to get the most from your new plan, we have created this guide. It includes more detailed information on your plan and how it works, as well as examples and a handy frequently asked questions section.

We hope you will use this guide as a resource throughout the year. However, if you have questions or need assistance, please give us a call at 1-877-298-2341, TTY 711, 8 a.m. to 8 p.m. local time, Monday through Friday. We are always willing to help.

Thank you for your membership and we look forward to serving you.

UnitedHealthcare



Benefit **HIGHLIGHTS**

Benefit Highlights

UnitedHealthcare® Group Medicare Advantage (PPO)

Public Education Employees' Health Insurance Plan

Group number: 15500

Effective January 1, 2017 to December 31, 2017

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions and restrictions may apply.

Plan costs	In-Network	Out-of-Network
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of \$166 each plan year	

Medical Benefits	In-Network	Out-of-Network
Benefits covered by Original Medicare and PEEHIP		
Doctor's office visit	Primary Care Provider: \$13 co-pay Specialist: \$18 co-pay	Primary Care Provider: \$13 co-pay Specialist: \$18 co-pay
Preventive services	\$0 co-pay for Medicare covered preventive services.	
Inpatient hospital care	\$200 co-pay per day: day 1; \$25 co-pay per day: days 2-5; \$0 co-pay per day after that	\$200 co-pay per day: day 1; \$25 co-pay per day: days 2-5; \$0 co-pay per day after that
Skilled nursing facility (SNF)	\$0 co-pay per day: days 1-20; \$161 co-pay per additional day up to 100 days	\$0 co-pay per day: days 1-20; \$161 co-pay per additional day up to 100 days
Outpatient surgery	\$0 co-pay	\$0 co-pay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	\$0 co-pay	\$0 co-pay
Diagnostic radiology services (such as MRIs, CT scans)	\$0 co-pay	\$0 co-pay
Lab services	\$0 co-pay	\$0 co-pay

Medical Benefits	In-Network	Out-of-Network
Outpatient X-rays	\$0 co-pay	\$0 co-pay
Therapeutic radiology services (such as radiation treatment for cancer)	\$0 co-pay	\$0 co-pay
Ambulance	\$0 co-pay	\$0 co-pay
Emergency care	\$35 co-pay (worldwide)	
Urgently needed services	\$18 co-pay	\$18 co-pay
Annual out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$6,700 each plan year	
Additional benefits and programs not covered by Original Medicare		
Routine physical	\$0 co-pay; 1 per plan year*	\$0 co-pay; 1 per plan year*
Routine chiropractic care	20% co-insurance per visit up to 18 visits per plan year*	20% co-insurance per visit up to 18 visits per plan year*
Foot care – routine	\$18 co-pay (up to 6 visits per plan year)*	\$18 co-pay (up to 6 visits per plan year)*
Hearing – routine exam	\$0 co-pay (1 exam every 12 months)*	\$0 co-pay (1 exam every 12 months)*
Hearing aids	\$500 allowance (every 3 years)*	\$500 allowance (every 3 years)*
Vision – routine eye exams	\$18 co-pay (1 exam every 12 months)*	\$18 co-pay (1 exam every 12 months)*
Fitness program through SilverSneakers®	Stay active with a basic membership at a participating location at no extra cost to you	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Visits	Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com/peehip .	

*Benefits are combined in and out-of-network.

Prescription Drugs	Your Costs			
	Non-maintenance Drugs	Maintenance Drugs		
	Network Retail Pharmacy (up to a 30-day supply of non-maintenance drugs)	Network Retail Pharmacy (up to a 30-day supply of maintenance drugs**)	Network Retail Pharmacy (31 to 60-day supply of maintenance drugs**)	Network Retail Pharmacy (61 to 90-day supply of maintenance drugs**)
Tier 1: Generic	\$6 co-pay	\$6 co-pay	\$12 co-pay	\$12 co-pay
Tier 2: Preferred brand	\$40 co-pay	\$40 co-pay	\$80 co-pay	\$120 co-pay
Tier 3: Non-preferred drug	\$60 co-pay	\$60 co-pay	\$120 co-pay	\$180 co-pay
Tier 4: Specialty Tier	\$60 co-pay	\$60 co-pay	\$120 co-pay	\$180 co-pay
Coverage gap stage	After your total drug costs reach \$3,700, the plan continues to pay its share of the costs of your drugs and you pay your share of the cost.			
Catastrophic coverage stage	<p>During this stage, the plan will pay most of the cost for your drugs.</p> <ul style="list-style-type: none"> Your share of the cost for a covered drug will be either co-insurance or a co-pay, whichever is the lesser amount between: <ul style="list-style-type: none"> — either — Your normal tier co-pay — or — 5% co-insurance on the cost of the drug OR a co-pay of \$3.30 for a generic drug or a drug that is treated like a generic and \$8.25 for all other drugs, whichever is the larger amount. Our plan pays the rest of the cost. 			

** Please see the Additional Drug Coverage in the Evidence of Coverage for a list of the plan's maintenance drugs. Your first fill of a new prescription for a maintenance drug is limited to a 30-day supply. After the first fill, you can receive up to a 90-day supply when the prescription is written for up to 90-days and no more than 130 days have lapsed between fills.



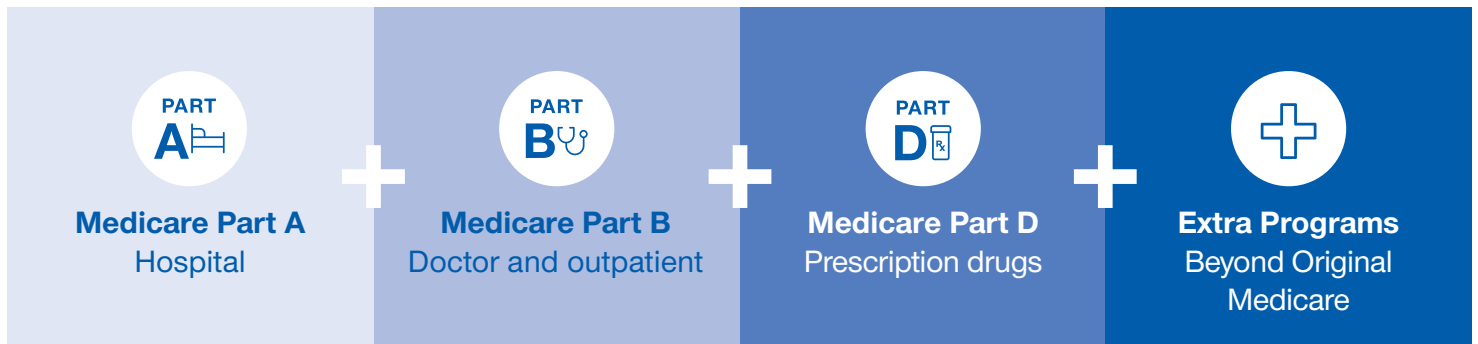
Plan **INFORMATION**



UnitedHealthcare® GROUP MEDICARE ADVANTAGE (PPO)

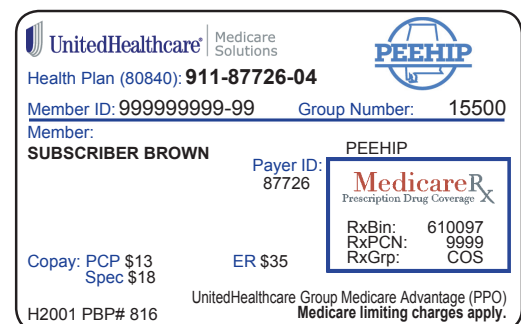
The Public Education Employees' Health Insurance Plan (PEEHIP) has chosen a UnitedHealthcare® Group Medicare Advantage plan to be your medical and prescription drug coverage beginning January 1, 2017. The word "Group" means this is a plan designed just for an employer group or plan sponsor, like yours. Only eligible retirees and their eligible dependents of your employer group or plan sponsor can enroll in this plan.

"Medicare Advantage" is also known as Medicare Part C. These plans combine all the benefits of Original Medicare including Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) plus extra programs that go beyond Original Medicare.



One plan. One ID card.

With all of your medical and prescription drug coverage now combined into one plan, you only need to use one ID card for your medical and prescription drug coverage. You no longer need to use your red, white and blue Medicare card plus additional cards for supplemental medical coverage and prescription drugs. Instead, each time you go to the doctor or hospital or fill a prescription, show your UnitedHealthcare Group Medicare Advantage (PPO) plan card.



Be sure to start using your new ID card from UnitedHealthcare as soon as your plan is effective. Using this card will help make sure that you pay the correct amount and that your claims are processed quickly and accurately.

Please note, while you no longer need to use your red, white and blue Medicare Card, you will still want to keep it and put it in a safe place.

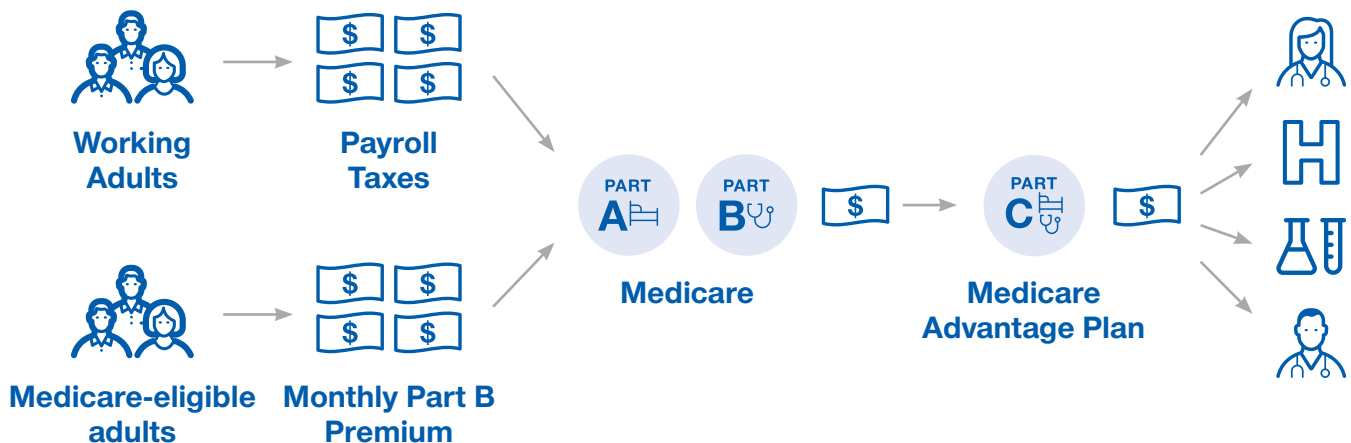


Your Medicare Advantage plan

HOW IT WORKS

So how do Medicare Advantage plans work? Simply put, Medicare (the government) allows Medicare Advantage plans to administer your Medicare benefits on its behalf. Medicare pays Medicare Advantage plans a fixed amount for each member of the plan. The Medicare Advantage plan then pays the hospitals, doctors and other health care professionals for all your Medicare covered benefits.

And where does Medicare get its money? Medicare gets its money from taxes that you paid while you were working. This helps pay for Medicare Part A or hospital coverage. Once you are eligible for Medicare and retire, you pay Medicare a monthly premium to help pay for Medicare Part B or medical coverage. This is why it's important to keep paying your monthly Part B premium, even though you are now a member of a Medicare Advantage plan.



Make sure you know what parts of Medicare you have.



You must be entitled to Medicare Part A and enrolled in Medicare Part B to enroll in this plan.

- If you're not sure if you are enrolled in Medicare Part B, check with your local Social Security office
- You must continue paying your Medicare Part B premium to keep your coverage under this group-sponsored plan
- If you stop your payments, you may be disenrolled from this plan



How your Group Medicare Advantage PLAN WORKS WITH OTHER COVERAGE

Medicare has certain rules about what types of coverage you can have either as an addition to or combined with a Group-sponsored Medicare Advantage plan.

1

Rule 1: One plan at a time.

Medicare only allows you to be enrolled in one Medicare Advantage plan and one Medicare Part D prescription drug plan at a time. If you enroll in another Medicare Advantage plan or a stand-alone Medicare Part D plan not offered by PEEHIP, you will be disenrolled from the PEEHIP-offered UnitedHealthcare Group Medicare Advantage (PPO) plan. Any family members will also be disenrolled from their PEEHIP-offered coverage and you and your family will not have hospital/medical or drug coverage with PEEHIP.



If you drop your PEEHIP group-sponsored retiree health coverage, you will not be able to reenroll until the next PEEHIP Open Enrollment period of July 1 through August 31 for an October 1 effective date.

2

Rule 2: You must have “like” coverage.

Medicare allows you to have different plans for medical (Medicare Advantage) and prescription drug (Part D) coverage but they must be the same type of plan. In this case, if you are transitioning to the PEEHIP-offered Medicare Advantage plan that includes medical only, your Medicare Part D coverage also must come through another group (like PEEHIP)-sponsored Part D prescription drug plan (or TRICARE). Your Part D coverage cannot be an individual Part D prescription drug plan. That would be a different type of plan. If you enroll in an individual Part D prescription drug plan — this does not include TRICARE — then you will be disenrolled from your PEEHIP-sponsored UnitedHealthcare® Group Medicare Advantage (PPO) plan.



Your choices FOR COVERAGE

1

Option 1:

PEEHIP members who are eligible for Medicare will be automatically enrolled in the UnitedHealthcare® Group Medicare Advantage (PPO) plan that includes hospital, medical AND prescription drug coverage unless they tell PEEHIP that they do not want to be enrolled.

2

Option 2:

PEEHIP members who have TRICARE prescription drug benefits or other group-sponsored Medicare Part D prescription drug coverage may choose to be enrolled in the PEEHIP-sponsored UnitedHealthcare® Group Medicare Advantage (PPO) plan that includes medical coverage only.

These are the only two options for medical coverage through PEEHIP.

All members are mailed a pre-enrollment packet that includes information and instructions on how to opt-out or change coverage. Medicare-eligible retirees and Medicare-eligible covered dependents considering opting out should contact PEEHIP to discuss what the decision means. PEEHIP can be reached at 1-334-517-7000 or toll free 1-877-517-0020.

If you opt-out of prescription drug coverage through PEEHIP because you have TRICARE or other group Medicare Part D prescription drug coverage, you can continue to be enrolled in the UnitedHealthcare® Group Medicare Advantage (PPO) plan that covers hospital and medical only. If you choose to opt out of both the hospital medical coverage AND the prescription drug coverage, you will not be permitted to reenroll until the next PEEHIP Open Enrollment period of July 1 – August 31 for an October 1 effective date. If you have family coverage and you choose to opt out of the UnitedHealthcare® Group Medicare Advantage (PPO) plan in its entirety, you will disenroll the entire family from PEEHIP-sponsored coverage.



Medical coverage PLAN BASICS

How your medical coverage works.

Your plan is a Preferred Provider Organization (PPO) plan. You have access to our national network of providers. Plus, you can see providers out-of-network and pay the same out-of-pocket costs as in-network providers, as long as they participate in Medicare and accept the plan.

	In-Network	Out-of-Network
Will the doctor or hospital accept my plan?	Yes	Yes, as long as they participate in Medicare and accept plan. ¹
What is my co-pay or co-insurance?	Co-pays and co-insurance vary by service. ²	
Do I need to choose a primary care provider (PCP)?	No	No
Do I need a referral to see a specialist?	No	No
Are emergency and urgently needed services covered?	Yes	Yes
Do I have to pay the full cost for all doctor or hospital services?	You will pay your standard co-pay or co-insurance for the service you get. ²	
Is there a limit on how much I spend on medical services each year?	Yes	Yes
Are there any situations when a doctor will balance bill me?	Under this plan you are protected from any balance billing when seeing physicians or health care providers who have not opted out of Medicare.	

¹This means that the provider or hospital agrees to treat you and be paid according to UnitedHealthcare's payment schedule. With this plan, we follow the Medicare fee schedule and follow Medicare's rules. Emergencies would be covered even if out-of-network.

²Refer to the Summary of Benefits or Benefit Highlights in this guide for more information.

Manage your account details online.



Once your plan is effective, create your secure online account at **www.UHCRetiree.com/peehip**. After you've registered, you can track your bills and payments, view your account history and plan details and so much more online.



Medical coverage PLAN BASICS

How your plan pays for your medical services.

As mentioned earlier, your Medicare Advantage plan pays for your covered medical services a little differently than your former PEEHIP Hospital Medical coverage. Your Medicare Advantage plan pays doctors and hospitals directly for your services instead of after Medicare. You may also pay a co-pay at the time of service rather than waiting for the bill to come from the doctor's office or hospital.

Remember, always show your UnitedHealthcare® Group Medicare Advantage (PPO) plan ID card when you go to the doctor or hospital. This will help make sure that you pay the correct amount for your services and that your claims are processed quickly and accurately. If you ever have questions about a claim, please call UnitedHealthcare customer service toll free at 1-877-298-2341, TTY 711, 8 a.m. to 8 p.m., local time, Monday through Friday.

To help understand what you pay and what your plan pays, here are some examples.

Martha — Inpatient Hospital Stay (Medicare Part A)

Martha came down with a severe case of pneumonia and was admitted to the hospital for 7 days. Here is what she pays:

	Plan Coverage	Martha Pays	Plan Pays
Day 1	\$200 co-pay, Day 1	\$200	All Additional Covered Costs
Days 2–5	\$25 co-pay per day, Days 2-5	\$100	All Additional Covered Costs
Days 6–7	\$0 co-pay per day there after	\$0	All Additional Covered Costs
Total = 7 days		Total = \$300	All Additional Covered Costs

Martha pays a total of \$300 for her stay of 7 days in the hospital. Because this is coverage under Medicare Part A (hospital) the \$300 does not count towards Martha's annual medical deductible of \$166, but it does count towards her annual out-of-pocket maximum — the most Martha would pay for medical services in a year — of \$6,700. If Martha is readmitted to an inpatient hospital within 60 days of original admission date for the identical primary diagnosis, all per day co-pays will be waived.



Medical coverage PLAN BASICS

Joe — Doctor's Office Visit (Medicare Part B)

In January, Joe goes to see his primary care doctor because of a persistent cough. Because it's early in the year, Joe has not yet met his annual medical deductible of \$166.

	Plan Coverage	Joe Pays	Plan Pays
Doctor's Office Visit	\$13 co-pay after deductible	All doctor visit costs up to \$166 to satisfy the annual deductible	Any additional visit costs after the deductible of \$166 is met

Joe pays all of the costs of his office visit up to \$166 which meets his annual medical deductible. Any costs over \$166 are paid by the plan. What Joe pays also would count towards his annual out-of-pocket maximum — the most Joe would pay for medical services in a year — of \$6,700.

Helen – Outpatient Surgery (Medicare Part B)

Helen needs to have some minor surgery that can be done on an outpatient basis. In preparation for the surgery, Helen has some X-rays and lab services.

	Plan Coverage	Helen Pays	Plan Pays
Outpatient X-rays	\$0 co-pay	\$0 co-pay	All Additional Covered Costs
Lab Services	\$0 co-pay	\$0 co-pay	All Additional Covered Costs
Outpatient Surgery	\$0 co-pay	\$0 co-pay	All Additional Covered Costs

Helen pays \$0 co-pays for the outpatient X-rays, lab services and outpatient surgery.

These examples are for illustration only. For complete information on your benefits and costs, please refer to your Summary of Benefits or Evidence of Coverage.



Getting the health care **COVERAGE YOU MAY NEED**



Your care begins with your doctor.

With this plan, you have the flexibility to see doctors that are both inside and outside the UnitedHealthcare network. You can use any doctor, hospital or other health care provider as long as they participate in Medicare and accept the plan. Unlike many other PPO plans, with this plan, you pay the same share of cost in and out-of-network. With your UnitedHealthcare® Group Medicare Advantage plan, you're connected to programs, resources, tools and people that can help you live a healthier life.

Finding a doctor is easy.



If you need help finding a doctor or a specialist, just give us a call. We can even help schedule that first appointment.

Why use a UnitedHealthcare network doctor?

If you need to find a new doctor or specialist, we hope you will consider a doctor in the plan's network. We work closely with our network of doctors to give them access to resources and tools that can help them.

We're just a phone call away.

Toll-Free **1-877-298-2341**, TTY **711**,
8 a.m. – 8 p.m. local time, Monday – Friday

Learn more online at
www.UHCRetiree.com/peehip



Getting the health care **COVERAGE YOU MAY NEED**

Additional support and programs.

At UnitedHealthcare, we want to make it easier for you and your doctor to take care of your health. Here are just a few of the ways we help.



Annual Wellness Visit and preventive services at \$0 co-pay¹

One of the best ways to stay on top of your health is with an Annual Wellness Visit with your doctor. Together, you can identify the preventive screenings you may need, review all your medications and talk about any health concerns. You may even get a reward just for completing your Annual Wellness Visit.



You are never alone with NurseLine.

Doctor's office not open? Whether it's a question about a medication or a health concern in the middle of the night, with NurseLine, registered nurses answer your call 24 hours a day.



Special programs for people with chronic or complex health needs.

UnitedHealthcare offers special programs to help doctors with their patients who are living with chronic disease, like diabetes or heart disease. The patients get personal attention and the doctor gets up-to-date information to help them make decisions.



Enjoy a clinical visit in the comfort of your own home.

HouseCalls is an annual health program offered to you for no extra cost. The program sends an advanced practice clinician who will visit you at home. During the visit, they will check your medical history and current medications. It can also give you a chance to ask any health questions you may have. Once completed, HouseCalls will send you a summary of your visit so you can share it with your doctor. HouseCalls may not be available in all areas.

¹If additional tests are required, there may be a co-pay or co-insurance.



Getting the health care **COVERAGE YOU MAY NEED**



See a doctor using your computer, tablet or mobile phone.

UnitedHealthcare's Virtual Doctor Visits lets you choose to see and speak to specific doctors using your computer or a mobile device, like a tablet or smart phone. These doctors are special providers that have the ability to offer virtual medical visits. During a virtual visit, you can ask questions, get a diagnosis and the doctor can even prescribe medication¹ that, if appropriate, can be sent to your pharmacy. You can find a list of participating virtual medical doctors online at www.UHCRetiree.com/peehip.



Get active and have fun with SilverSneakers® Fitness.

Designed for all fitness levels and abilities, SilverSneakers includes access to exercise equipment, classes and more than 13,000 participating locations. SilverSneakers signature classes, offered at select locations, are led by certified instructors trained specifically in adult fitness and include a range of options from using light hand weights to more intense circuit training. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. For more information, visit www.silversneakers.com.



Make caring for a loved one easier.

At no additional cost, Solutions for Caregivers supports you, your family and those you care for by providing information, education, resources and care planning. Also included is an on-site evaluation by a Registered Nurse and a personal plan of care developed by a Geriatric Case Manager. You will also have access to our Caregiver Partners website so you can explore our library of articles, buy caregiver related products and services and share information among family members to help improve communication and decision-making.

¹Doctors can't prescribe medications in all states.



Prescription drug coverage

PLAN BASICS

How your prescription drug coverage works.

Your Medicare Part D prescription drug coverage includes thousands of brand name and generic prescription drugs. To check if your drugs are covered, please review your plan's drug list.

How it works.



What pharmacies can I use?

In order to use the prescription drug benefits that are part of your plan, you must use a pharmacy that is in UnitedHealthcare's network. You can choose from over 67,000 pharmacies¹ across the United States including national chain, regional and independent local retail pharmacies. If you do not use a pharmacy in UnitedHealthcare's network, you may have to pay the full price of the drug.



What is a drug cost tier?

Drugs are divided into different cost levels or tiers. In general, the higher the tier, the higher the cost of the drug.



What will I pay for my prescription drugs?

What you pay will depend on the coverage your employer group or plan sponsor has arranged. Your exact cost may depend on what drug cost tier your prescription belongs to. Your cost may also change during the year based on the total cost of the drugs you have taken.²



Do I need to keep paying my Part B monthly premium?

Yes. Medicare requires that you continue to pay your Part B monthly premium (to Social Security). If you stop paying your monthly Part B premium, you will be disenrolled from your plan.



Can I have more than one prescription drug plan?

No. You can only have one Medicare prescription drug plan at a time. If you enroll in another Medicare prescription drug plan OR a Medicare Advantage plan that includes prescription drug coverage, you will be disenrolled from this plan.



Can a pharmacist change my prescription from a brand name drug to a generic drug?

Yes. A participating pharmacy must dispense a generic medication when one is available according to Act 2002-266 Generic Equivalent Drug Section 16-25A-18, Code of Alabama 1975. As a condition of participation in PEEHIP, a pharmacist shall dispense a generic equivalent medication to fill a prescription for a patient covered by PEEHIP when one is available unless the physician indicates in long hand on the prescription "medically necessary" or "dispense as written" or "do not substitute". The generic equivalent drug will be pharmaceutically and therapeutically equivalent and contain the same active ingredient or ingredients and will be of the same dosage, form and strength.

¹2015 Internal Report Data

²Refer to the Summary of Benefits or Benefit Highlights for more information.



Prescription drug coverage **PLAN BASICS**



What is a Medicare Part D Late Enrollment Penalty (LEP)?

If, at any time after you first become eligible for Part D, there's a period of at least 63 days in a row when you don't have Part D or other creditable prescription drug coverage, a late enrollment penalty may apply. Creditable coverage is prescription drug coverage that is at least as good as or better than what Medicare provides. The late enrollment penalty is an amount added to your monthly Medicare premium which you may have to pay. When you become a member, your employer group or plan sponsor will be asked to confirm that you have had continuous Part D plan coverage. If your employer group or plan sponsor asks for information about your prescription drug coverage history, please respond as quickly as possible to avoid an unnecessary penalty. Once you become a member, more information will be available in your Evidence of Coverage (EOC).

Call Medicare to see if you qualify for Extra Help.

If you have a limited income, you may be able to get Extra Help from Medicare. If you qualify, Medicare could pay up to 75% or more of your drug costs. Many people qualify and don't know it. There's no penalty for applying, and you can re-apply every year.



Toll-Free **1-800-633-4227**, TTY **1-877-486-2048**, 24 hours a day, 7 days a week



Ways to **HELP YOU SAVE**

One of the advantages of having your health care coverage through UnitedHealthcare is our size and experience. As one of the largest and oldest Medicare Advantage and Medicare prescription drug plans in the country, we bring you savings that are exclusive to UnitedHealthcare.



Pharmacy Saver.

Pharmacy Saver is a cost-saving prescription drug program available to you as a plan member. UnitedHealthcare has worked with many of our network pharmacies to offer even lower prices on many common generic prescription drugs.¹

Best of all, it's easy. No additional enrollment is necessary. Simply take your qualifying prescription to a participating pharmacy, show your UnitedHealthcare member ID card, and they can help you switch.

The UnitedHealthcare Savings Promise



UnitedHealthcare is committed to keeping your costs down for prescription drugs. As a member of our Medicare Advantage Prescription Drug plans, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan co-pay, the pharmacy's retail price or our contracted price with the pharmacy.



Filling your prescriptions is convenient.

UnitedHealthcare has over 67,000 national, regional and local chains, as well as thousands of independent neighborhood pharmacies in its network.



¹Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements. If a prescription is in excess of a limit, then co-pay amounts may be higher.

²2015 Internal Report Data



To see a listing of drugs available through Pharmacy Saver or to find a participating pharmacy, visit **[UnitedPharmacySaver.com](https://www.unitedpharmasaver.com)**.




More ways you could save **ON YOUR PRESCRIPTION DRUGS**

You could save money on prescription drugs with exclusive member pricing at pharmacies in your local grocery, drug and discount stores.

Get a 90-day¹ supply at retail pharmacies on maintenance medications.

Most retail pharmacies offer 90-day supplies for some prescription drugs.

To find out if a retail pharmacy offers 90-day supplies, you can check your UnitedHealthcare pharmacy directory. Visit www.UHCRetiree.com/peehip to find pharmacies near you or call customer service toll-free at **1-877-298-2341**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday to request a printed directory. Look for the  symbol to see if a retail pharmacy offers 90-day supplies.

Ask your doctor about trial supplies.

A trial supply allows you to fill a prescription for less than 30 days. This way, you can pay a reduced co-pay or co-insurance and make sure the medication works for you before getting a full month's supply.

Explore lower cost options.

Each covered drug in your drug list is assigned to a tier. Generally, the lower the tier, the less you pay. If you're taking a higher-tier drug, you may want to talk to your doctor to see if there's a lower-tier drug you could take instead.

Have an annual medication review.

Take some time during your Annual Wellness Visit to make sure you are only taking the drugs you need.

¹Your employer group or plan sponsor may provide coverage beyond 90 days. Please refer to the Benefit Highlights or Summary of Benefits for more information.

We're just a phone call away.

Toll-Free **1-877-298-2341**, TTY **711**,
8 a.m. – 8 p.m. local time, Monday – Friday

Learn more online at
[**www.UHCRetiree.com/peehip**](http://www.UHCRetiree.com/peehip)



Tools and resources **TO PUT YOU IN CONTROL**

Good health care decisions may help you to live healthier and may help lower your health care costs. It's no secret that health care has become more complicated. UnitedHealthcare strives to make it easier by giving you the tools and resources you may need to help make good health decisions for you.



Valuable information is just a few clicks away.

As a UnitedHealthcare member, you will have access to a safe, secure and personalized website that gives you access 24 hours a day to:

- Look up your latest claim information
- Review your personal health record
- Search for network doctors
- Search for drugs and how much they cost under your plan
- Learn more about health and wellness topics and sign up for healthy challenges that are based on your interests and goals

We're just a phone call away.

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Questions?

WE HAVE ANSWERS



Questions? **WE HAVE ANSWERS**



General Questions:

Do I need Original Medicare (Part A and Part B)?

It is important to know that Medicare-eligible retired members and Medicare-eligible dependents must be enrolled in Part A AND Part B of Medicare to have coverage with the new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP. If you do not have both Part A and Part B, you will not be eligible for the Medicare Advantage plan and you will not have hospital, medical or prescription drug coverage with PEEHIP.

What if I don't want prescriptions drug coverage?

Medicare-eligible PEEHIP members who have TRICARE, or another group-sponsored, Medicare Part D plan may opt-out of the prescription drug coverage and enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan that includes medical coverage only. You must tell PEEHIP if you want to opt-out of prescription drug coverage. Information and instructions on how to opt-out are included in a pre-enrollment packet. You can also call PEEHIP at 1-334-517-7000 or Toll Free 1-877-517-0020.

Remember:

- You are responsible for any premium and drug costs associated with your separate prescription drug plan. This coverage is outside what is offered by PEEHIP.
- If you choose to opt-out of the prescription drug coverage through PEEHIP's UnitedHealthcare® Group Medicare Advantage (PPO) plan, make sure you continue to have TRICARE or other group-sponsored Medicare Part D prescription drug coverage. If you do not have continuous prescription drug coverage, you could risk paying a penalty should you choose later to join a plan that has Medicare prescription drug coverage.

What happens if I have dependents that are not yet eligible for Medicare?

The Medicare-eligible retiree's spouse or other covered dependents who are not Medicare eligible will remain in the PEEHIP (non-Medicare) hospital medical and prescription drug plan. The non-Medicare dependent(s) should continue to use their current PEEHIP ID card and will not be enrolled in the UnitedHealthcare® Group Medicare Advantage (PPO) plan until the dependent(s) becomes Medicare eligible.

IMPORTANT: If you opt out of either of the Group Medicare Advantage (PPO) plan options, you will not be permitted to reenroll until the next PEEHIP Open Enrollment period of July 1 through August 31 for an October 1 effective date. If you have family coverage and you choose to opt out of the Group Medicare Advantage plan options, you will disenroll the entire family from any medical and prescription drug coverage.



Questions? **WE HAVE ANSWERS**



Medical Coverage Questions:

What should I do if I am told that I need an authorization to get a procedure done that never needed an authorization before?

This is a new plan that has its own authorization requirements. If a procedure requires an authorization, the provider needs to submit the required documentation so that a coverage decision can be made. Coverage decisions are made within 14 days for standard requests and within 72 hours for urgent requests.

What do I need to know about the UnitedHealthcare provider network? How do I find out if my doctor is in the network? What is the name of the network?

The UnitedHealthcare® Group Medicare Advantage (PPO) plan is a Preferred Provider Organization (PPO) plan and does not have restrictions on in and out-of-network coverage. You have access to our national network and can see any provider as long as the provider participates in the Medicare program and accepts the plan; the provider does not have to be in the UnitedHealthcare network. When you go out-of-network for care, the PPO plan pays providers just as much as Medicare would have paid, and you pay the same out-of-pocket copayment as if you had stayed in the network. If you have questions about whether or not your doctor is in the network, please give UnitedHealthcare a call, they will be happy to call your doctor and explain how the plan works to your doctor (and office staff) so that they are comfortable accepting this plan.

What is the difference between in-network and out-of-network providers? How does this difference affect the total amount that I can expect to pay for services when using out-of-network providers?

In-network providers have a contract with UnitedHealthcare. Out-of-network providers do not have a contract. With this plan, you have the flexibility to see doctors that are both inside and outside the UnitedHealthcare network. Unlike most PPO plans, with this plan, you pay the same share of cost in and out-of-network. Also, when you go out-of-network for care, the plan pays providers just as much as Medicare would have paid.

My doctor says that he/she does not accept Medicare Advantage plans as insurance. What can I do?

Call your UnitedHealthcare dedicated customer service team who will be happy to help you at the number on the back of your ID card. The UnitedHealthcare® Group Medicare Advantage (PPO) plan works differently than traditional Medicare Advantage plans and as a result, your doctor may not be familiar with how it works. We are happy to call your doctor and explain how the plan works to your doctor (and office staff) so that they are comfortable accepting this plan.



Questions? **WE HAVE ANSWERS**

What happens if my doctor does not accept Medicare Advantage plans?

What happens if a doctor accepts Medicare but doesn't accept this plan?

There are many different types of Medicare Advantage plans so it depends on what your doctor does not accept. The UnitedHealthcare® Group Medicare Advantage (PPO) plan does not require a doctor to have a contract with UnitedHealthcare. This plan works like traditional PPO plans which doctors have been familiar with for a long time. Under the plan, the doctor will be paid the same as Medicare. Most doctors accept this type of plan once they understand they do not need a contract and they will be paid the same as Medicare. If you contact UnitedHealthcare, we will be happy to reach out to your provider to discuss how the plan works and how the provider will be paid the same as Medicare. If the doctor refuses to accept this plan, you can continue to see the doctor, pay for the services upfront and then submit the bill to UnitedHealthcare for reimbursement. You will only be responsible for the same co-payment or co-insurance as if you had stayed in the network.

What happens if my doctor does not participate in Medicare?

If your doctor has opted out the Medicare program in its entirety, you would only have plan coverage in an emergency situation. This is no different than your former medical plan. Less than 1% of doctors nationally have opted out of the Medicare program. If you need help finding a doctor, UnitedHealthcare can help you find a doctor based on your needs.

How are out-of-network claims processed?

Whether your provider is in network or out of network, your provider can submit claims to UnitedHealthcare to be processed electronically. If needed, the UnitedHealthcare claim address information is provided on your Member ID card and in your Welcome Kit. UnitedHealthcare administers claim payments for out-of-network providers in compliance with all federal regulations.

Are there any situations when a doctor will balance bill me?

Under this plan, you are protected from any balance billing. When you go out-of-network for care, the PPO plan pays providers just as much as Medicare would have paid, and you pay the same co-payment or co-insurance as if you had stayed in the network. If your doctor attempts to balance bill you, please contact UnitedHealthcare.



Questions? **WE HAVE ANSWERS**



Prescription Drug Coverage Questions:

What is Medicare Part D IRMAA and does it apply to me?

IRMAA stands for Income Related Monthly Adjustment Amount. Similar to Medicare Part B, high income earners will pay more for their Medicare Part D coverage. Any Medicare Part D plan member whose Modified Adjusted Gross Income as reported on your IRS tax return is above \$85,000 for an individual or \$170,000 for a couple, may pay an additional amount for Medicare Part D coverage. The extra amount is paid directly to Medicare, not to your plan. If you are subject to IRMAA, Social Security will send you a letter. The letter will explain how they determined the amount you must pay and the actual IRMAA amount. Neither your employer group nor your health plan determines who will be subject to IRMAA. Therefore, if you disagree with the amount you must pay, you must contact the Social Security Administration. You can:

- Go online to www.ssa.gov
- Call Social Security at 1-800-772-1213, TTY 1-800-325-0778
- Visit your local Social Security office

Who is OptumRx and what is its relationship to UnitedHealthcare?

UnitedHealthcare provides the insurance and pays the claims for your pharmacy benefits. It also has the contract with Medicare. OptumRx is the pharmacy benefit manager for UnitedHealthcare that processes all of the claims and administrative work on UnitedHealthcare's behalf. Both UnitedHealthcare and OptumRx are part of UnitedHealth Group.

What if my drug is not on the covered drug list (formulary)?

If you find that the drug you are taking will not be covered, talk to your doctor to see if other options are available for you. You may be eligible for at least a 30-day supply transition fill that allows you time to talk to your doctor. If none of the other drug options work for you, either you or your doctor can request an exception to have the drug covered for you. You can request the exception by calling UnitedHealthcare Customer Service. Your doctor can call OptumRx directly at 1-800-711-4555, TTY 711, 7 a.m. to 2 a.m. CT, Monday through Friday; 8 a.m. to 5 p.m. CT, Saturday.

What if the drug I'm taking requires a prior authorization?

If the drug you are taking requires a prior authorization, in many cases you will be given at least a 30-day supply to give you time to talk to your doctor. This is called a "transition fill". If your doctor decides to keep you on the drug, you or your doctor can ask for coverage of the drug in 2017 by calling UnitedHealthcare Customer Service at 1-877-298-2341, TTY 711, 8 a.m. to 8 p.m. local time, Monday through Friday. If you continue to fill your prescriptions for the drug without getting a prior authorization, the drug will not be covered and you may have to pay the full retail price.



Questions? **WE HAVE ANSWERS**

What is a transition fill?

A transition fill is a temporary supply of a prescription drug that is either not covered on the drug list, or for which your ability to get the drug is limited. This transition fill can provide at least a 30-day supply of your drug during the first 90 days of the transition to UnitedHealthcare. This works for prescriptions filled at retail locations. If you receive a transition fill, you and your doctor will receive a notification along with information explaining your options. Transition fills are provided for many Medicare Part D eligible drugs that require prior authorization, step therapy, have a quantity restriction, or are not covered on the drug list. Please note: A drug that changes to a higher co-pay but is still a covered drug, is not eligible for a transition fill.

What if I go to a non-network pharmacy?

If you go to a pharmacy that is not in the UnitedHealthcare pharmacy network — in other words, a non-network pharmacy — the pharmacy may not be able to submit the prescription claim directly to us for payment and you will have to pay the full retail price of the drug out of your pocket. You will need to submit a manual claim, which is also called Direct Member Reimbursement. You will be responsible for your co-pay plus any difference between the in-network price and the price you paid. You can download a copy of the claim form at www.UHCRetiree.com/peehip or call UnitedHealthcare Customer Service toll free at 1-877-298-2341, TTY 711, 8 a.m. to 8 p.m. local time, Monday through Friday and ask for the form.



Mail your claim form together with copies of any bills or receipts to us at this address:

OptumRx
PO Box 29045
Hot Springs, AR 71903

You must submit your Part D (prescription drug) claim to us within 36 months of the date you received the service, item, or drug.



Words **TO KNOW**



Words TO KNOW

Health care and health insurance terms can be hard to understand.

Here are some definitions of common words you will see in materials we send you. Feel free to refer back to these definitions whenever you get new communications from us.

Authorized representative

Your health information is protected by law. This means only you can get information about your health plan. However, you can give someone else — an authorized representative — access to speak with us about your account. This person does not have the right to make plan decisions for you. Your authorized representative can be a spouse, family member, friend, caregiver or someone else you trust.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. The health insurance or plan pays the rest of the allowed amount.

Co-payment (or co-pay)

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount of money you must pay each year before the plan starts to pay its share. Not all plans have deductibles.

Evidence of Coverage (EOC)

A summary that tells you what your health plan will and will not pay for.

Explanation of Benefits (EOB)

A statement that gives all of the details about what the health insurance plan covers, what the plan does not cover, how much money needs to be paid, and more. You will get one statement for medical services and, if appropriate, a different statement for prescription drugs.

Medicare Part B Premiums

You must continue to pay your Part B monthly premium to Social Security. If you do not pay your monthly Part B premium, you may be disenrolled from your plan, losing important coverage.

Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, or health care your health insurance or plan doesn't cover.

Preventive care

Health care services that are intended to prevent disease or identify disease while it may be easier to treat. Preventive care is covered by your plan. Examples include flu shots, colonoscopies, mammograms or prostate exams.

Primary care provider (PCP)

A physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.



Helpful RESOURCES



Helpful resources for your **UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (PPO) PLAN**

Resource	Description	Contact
PEEHIP	Plan Sponsor	334-517-7000 or toll free 877-517-0020 www.rsa-al.gov/index.php/members/peehip
NurseLine ¹	24/7 access to a nurse	1-877-365-7949, TTY 711 , 24 hours a day, 7 days a week
Pharmacy Saver	Discounts on select generic drugs	www.UnitedPharmacySaver.com
Renew by UnitedHealthcare®	Tips for more positive living	www.UHCRetiree.com/peehip
hi HealthInnovations®*	Discounts on hearing aids	1-855-523-9355, TTY 711 , 9 a.m. – 5 p.m. CT, Monday – Friday www.hiHealthInnovations.com/medicare
SilverSneakers® ²	Fitness program	1-888-423-4632, TTY 711 , 8 a.m. – 8 p.m. ET, Monday – Friday; www.silversneakers.com
Solutions for Caregivers ³	Help caring for loved ones	1-866-896-1895, TTY 711 , 24 hours a day, 7 days a week; www.UHCforCaregivers.com
Virtual Visits	Virtual Doctor Visits from your computer or device	www.UHCRetiree.com/peehip



UnitedHealthcare® Customer Service

Call for questions about your plan, to update your contact information, help finding a doctor, scheduling medical appointments and more.

Toll-Free **1-877-298-2341**, TTY **711**, 8 a.m. – 8 p.m. local time, Monday – Friday



UnitedHealthcare® Member Website

Register online to access your plan information, health and wellness information and much more.

www.UHCRetiree.com/peehip



*The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare® Group Medicare Advantage (PPO) Plan grievance process.



2017 Required INFORMATION

¹NurseLine should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The service is not an insurance program and may be discontinued at any time.

²Consult a health care professional before beginning any exercise program. Availability of the SilverSneakers program varies by plan/market. Refer to your Evidence of Coverage for more details. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.

³Solutions for Caregivers assists in coordinating community and in-home resources. The final decision about your care arrangements must be made by you. In addition, the quality of a particular provider must be solely determined and monitored by you. Information provided to you about a particular provider does not imply and is in no way an endorsement of that particular provider by Solutions for Caregivers. The information on and the selection of a particular provider has been supplied by the provider and is subject to change without written consent of Solutions for Caregivers.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, co-pay amounts may be higher.

Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments and restrictions may apply.

Benefits, premium and/or co-payments/co-insurance may change each plan year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

Non-Discrimination Notice

UnitedHealthcare Insurance Company, on behalf of itself and its affiliated companies, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, please call the toll-free member phone number listed on your ID card, TTY 711.

If you believe that UnitedHealthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
UHC_Civil_Rights@uhc.com

You can file a grievance by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-298-2341 (TTY: 711). Si ya es miembro, llame al número que aparece en la parte de atrás de su tarjeta de ID de miembro.

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-298-2341 (TTY: 711)。如果您已經是會員，請撥打會員卡背面的電話號碼。

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-298-2341 (TTY: 711). Kung ikaw ay miyembro na, pakitawagan ang numero na nasa likod ng iyong ID card ng Miyembro.

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-298-2341 (ATS: 711). Si vous êtes déjà un affilié, veuillez appeler le numéro figurant au dos de votre carte d'affilié.

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-298-2341 (TTY: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-298-2341 (TTY: 711). Wenn Sie bereits Mitglied sind, rufen Sie bitte die Nummer auf der Rückseite Ihres Mitgliedsausweises an.

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-298-2341 (TTY: 711) 번으로 전화해 주십시오. 귀하가 이미 회원이신 경우, 귀하의 회원 ID 카드 뒷면에 기재된 전화번호로 문의하십시오.

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-298-2341 (телетайп: 711). Если вы уже являетесь участником, позвоните по номеру телефона, указанному на обратной стороне вашей идентификационной карты.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1432-892-778-1 (رقم هاتف الصم والبكم: 711).

توضيح: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1432-892-778-1 (رقم هاتف الصم والبكم: 711).

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-298-2341 (TTY: 711). Se Lei è già un membro, chiami il numero indicato sul retro della tessera identificativa di membro.

Portuguese:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-298-2341 (TTY: 711). Se já for membro, ligue para o número que se encontra no verso do seu cartão de ID de membro.

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-298-2341 (TTY: 711). Si ou se yon manm deja, tanpri rele nimewo ki dèyè kat ID Manm ou.

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-298-2341 (TTY: 711). Jeśli jesteś już członkiem, zadzwoń pod numer podany na odwrocie Twojej karty członkowskiej.

Hindi:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-298-2341 (TTY: 711) पर कॉल करें। यदि आप पहले से ही सिस्य हैं, तो कृपया अपने सिस्य पहचान-पत्र के पीछे दिए गए नंबर पर कॉल करें।

Japanese:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-298-2341 (TTY: 711) まで、お電話にてご連絡ください。すでにメンバーになられている場合は、メンバーIDカードの裏面に記載されている番号 にお電話ください。

Farsi (Persian):

1-877-298-2341 سامت دیريگي. مهارف امشد یاريد ناگيار تروصب ی نابز تلايهست، دينک ی م وگتفگ ی سراف نابز ی رگا: هجوت تم اس بگيريدي. اگر قبل ا عضو شده ايد، لطفا با شماره قيدي شده روی پشت کارت ی م دشاب. اب (TTY: 711) شناسايی عضويت خود

