

# Annual Notice of Change 2027

Peoples Health Secure Health (HMO-POS D-SNP) Greater New Orleans, Baton Rouge and River Areas



Download the **UnitedHealthcare** app



Visit **[mypeopleshealthplan.com](https://mypeopleshealthplan.com)**



Call toll-free **1-877-367-1803**, TTY **711**

8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept

**PEOPLES HEALTH**

A UnitedHealthcare Company

# More information will be available online after October 15, 2026

This Annual Notice of Change (ANOC) provides important highlights about changes to your plan for next year, but it may not include all the updates.

To see the complete and most up-to-date details for your plan, review 2027 plan materials at [mypeopleshealthplan.com](https://mypeopleshealthplan.com) after October 15, 2026.



## **Provider Directory**

Confirm that your providers (primary care provider, specialists, hospitals, etc.) will be in the network next year.



## **Pharmacy Directory**

See which pharmacies are in our network next year.



## **Drug List (Formulary)**

Confirm that your drugs will be covered by your plan next year and review any new restrictions on our website.



## **Evidence of Coverage (EOC)**

Review your 2027 EOC for details about plan costs and benefits. The EOC is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. It also has information about the quality program, how medical coverage decisions are made and your rights and responsibilities as a member.

We know some members prefer having paper copies of their plan materials. Call or chat with our Customer Service if you'd like printed 2027 plan materials. We're happy to send them to you at no cost.

You can also visit [mypeopleshealthplan.com](https://mypeopleshealthplan.com) to sign up for paperless delivery.

## **Your enrollment will continue automatically**

If this is still the right plan for you, you don't need to take any action to stay enrolled in the plan for next year. Your enrollment will continue automatically.

# Annual Notice of Change for 2027



**You're enrolled as a member of Peoples Health Secure Complete (HMO-POS D-SNP).**

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Peoples Health Secure Health (HMO-POS D-SNP).
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your Medicare & You 2027 handbook.
- You don't need to take any action to stay enrolled in this plan for next year - your enrollment will continue automatically.
- **Note this is only a summary of changes. More information about costs, benefits, and rules is in the Evidence of Coverage. Get a copy at [mypeopleshealthplan.com](https://mypeopleshealthplan.com) or call Customer Service at 1-877-367-1803 (TTY users call 711) to get a copy by mail.**

## More Resources

- UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
- UnitedHealthcare provides free services to help you communicate with us such as materials in other languages, braille, large print, audio, or you can ask for an interpreter. Call us toll-free at the number on your UnitedHealthcare UCard® or the front of your plan booklet.
- UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comuniquen con nosotros. Por ejemplo, materiales en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Llámenos al número gratuito que se encuentra en su UCard® de UnitedHealthcare o en la portada de la guía de su plan.

## About Peoples Health Secure Health (HMO-POS D-SNP)

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.
- Our plan also has a written agreement with the Louisiana Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means Peoples Health Secure Health (HMO-POS D-SNP).
- On January 1, 2027, UnitedHealthcare Insurance Company or one of its affiliates will be transitioning you from Peoples Health Secure Complete (HMO-POS D-SNP) to Peoples Health Secure Health (HMO-POS D-SNP). This material tells you about the differences between your current benefits in Peoples Health Secure Complete (HMO-POS D-SNP) and the benefits you'll have on January 1, 2027, as a member of Peoples Health Secure Health (HMO-POS D-SNP).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Peoples Health Secure Health (HMO-POS D-SNP).** Starting January 1, 2027, you'll get your medical and drug coverage through Peoples Health Secure Health (HMO-POS D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

# Annual Notice of Change for 2027

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## Summary of important costs for 2027

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, you pay a \$0 copayment for your deductible, doctor office visits, and inpatient hospital stays.

|                                                                                                                                                                      | 2026 (this year)                                                                                                                                                                                                                                       | 2027 (next year)                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>*Your premium can be higher or lower than this amount.<br>(Go to Section 1.1 for details.)                                           | \$32.40                                                                                                                                                                                                                                                | \$17                                                                                                                                                                                                                                                   |
| <b>Annual medical deductible</b>                                                                                                                                     | For 2026, your plan has a \$283 deductible. The deductible does not apply to insulin furnished through durable medical equipment (DME).                                                                                                                | For 2027, your plan does not have a deductible.                                                                                                                                                                                                        |
| <b>Maximum out-of-pocket amounts</b><br>This is the <b>most</b> you'll pay out-of-pocket for covered Part A and Part B services.<br>(Go to Section 1.2 for details.) | From network providers: \$9,250<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. | From network providers: \$4,900<br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. |
| <b>Primary care office visits</b>                                                                                                                                    | You pay 20% of the total cost per visit.                                                                                                                                                                                                               | You pay a \$0 copayment per visit.                                                                                                                                                                                                                     |
| <b>Specialist office visits</b>                                                                                                                                      | You pay 20% of the total cost per visit.                                                                                                                                                                                                               | You pay a \$10 copayment per visit.                                                                                                                                                                                                                    |

**Questions?** Get answers on the UnitedHealthcare app or Chat with us at [mypeopleshealthplan.com](https://mypeopleshealthplan.com). You can also call Customer Service at **1-877-367-1803**, TTY **711**, 8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept

|                                                                                                                                                                                                                                                                         | 2026 (this year)                                                                                                                                                                                 | 2027 (next year)                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient hospital stays</b><br>Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | You pay a \$1,970 copayment for each Medicare-covered hospital stay for unlimited days.                                                                                                          | You pay a \$195 copayment each day for days 1 to 10.<br>\$0 copayment for additional Medicare covered days.                                                                                      |
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.7 for details.)                                                                                                                                                                                              | <b>If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs</b>                                                                                               |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                         | \$0                                                                                                                                                                                              | \$0                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                         | <b>If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs</b>                                                                                           |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                         | \$0 Tier 1<br>\$615 Tier 2, Tier 3, Tier 4 and Tier 5, except for covered insulin products and most adult Part D vaccines.                                                                       | \$0 Tier 1<br>\$700 Tier 2, Tier 3, Tier 4 and Tier 5, except for covered insulin products and most adult Part D vaccines                                                                        |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)                                                                                                                        | <b>If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs</b>                                                                                               |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                         | If you are enrolled in Medicare A and B and receive Louisiana Department of Health (Medicaid) benefits, depending on your income and institutional status, you pay one of the following amounts: | If you are enrolled in Medicare A and B and receive Louisiana Department of Health (Medicaid) benefits, depending on your income and institutional status, you pay one of the following amounts: |

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|  | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>For generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$1.60 copayment or</li> <li>• \$5.10 copayment</li> </ul> <p>For all other covered drugs:</p> <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$4.90 copayment or</li> <li>• \$12.65 copayment</li> </ul> <p>If the total amount you pay for copayments and coinsurance reaches \$2,100, you pay nothing for your covered Part D drugs.</p> | <p>For generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$1.65 copayment or</li> <li>• \$5.80 copayment</li> </ul> <p>For all other covered drugs:</p> <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$5 copayment or</li> <li>• \$14.40 copayment</li> </ul> <p>If the total amount you pay for copayments and coinsurance reaches \$2,400, you pay nothing for your covered Part D drugs.</p> |
|  | <p><b>If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs</b></p>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|  | <p>Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage stage:</p> <p>Drug Tier 1: Standard retail cost-sharing (in-network) \$0 per prescription.</p> <p>Drug Tier 2: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Drug Tier 3: Standard retail cost-sharing (in-network) 25% of the total cost.</p>                                                                                                                                                  | <p>Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage stage:</p> <p>Drug Tier 1: Standard retail cost-sharing (in-network) \$0 per prescription.</p> <p>Drug Tier 2: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Drug Tier 3: Standard retail cost-sharing (in-network) 25% of the total cost.</p>                                                                                                                                               |



**Questions?** Get answers on the UnitedHealthcare app or Chat with us at [mypeopleshealthplan.com](https://mypeopleshealthplan.com). You can also call Customer Service at **1-877-367-1803**, TTY **711**, 8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept

|  | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>You pay 25%, up to \$35 per month supply of each covered insulin product on this tier<sup>1</sup></p> <p>Drug Tier 4: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Drug Tier 5: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"> <li>• During this payment stage, you pay nothing for your covered Part D drugs.</li> </ul> | <p>You pay 25%, up to \$35 per month supply of each covered insulin product on this tier<sup>1</sup></p> <p>Drug Tier 4: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Drug Tier 5: Standard retail cost-sharing (in-network) 25% of the total cost.</p> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"> <li>• During this payment stage, you pay nothing for your covered Part D drugs.</li> </ul> |

<sup>1</sup> In 2026, you pay no more than \$35 for each 1-month supply of Part D covered insulin drugs. In 2027, you'll pay no more than a \$35 copay or 25% of the total drug cost—whichever is less—until you reach the Catastrophic Coverage stage where your cost drops to \$0. You pay these amounts even if you haven't paid your deductible.

## Section 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

|                                                                                                                                                                                                                                                                                                                                             | 2026 (this year)                                                                                                                      | 2027 (next year) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)                                                                                                                                                                                                          | <b>\$32.40</b>                                                                                                                        | <b>\$17</b>      |
| <b>Part B premium reduction</b><br>This amount will be deducted from your Part B premium. This means you'll pay less for Part B.<br>If your Part B premium is lower than the reduction amount, you won't get the difference as a cash payment. The reduction only applies to what you owe for Part B unless it is paid for you by Medicaid. | <b>Up to \$0.60</b><br>If your Medicare Part B premium is paid by Medicaid, or others on your behalf, you will not see the reduction. | <b>\$0</b>       |

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2026 (this year)                                                                                                                                                                                                                      | 2027 (next year)                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amount</b><br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.<br>Your costs for covered medical services (such as copayments) from network providers <b>count</b> toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for | <b>\$9,250</b><br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. | <b>\$4,900</b><br>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. |

|                                                                                 | 2026 (this year)                                                                                                                                                                                                               | 2027 (next year)                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. | Once you've paid \$9,250 out-of-pocket for covered Part A and Part B services from network providers, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year. | Once you've paid \$4,900 out-of-pocket for covered Part A and Part B services from network providers, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year. |

### Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 Provider Directory ([mypeopleshealthplan.com](http://mypeopleshealthplan.com)) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated Provider Directory:

- Visit our website [mypeopleshealthplan.com](http://mypeopleshealthplan.com).
- Call Customer Service at 1-877-367-1803 (TTY users call 711) to get current provider information or to ask us to mail you a Provider Directory.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-877-367-1803 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your Evidence of Coverage.

### Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2027 Pharmacy Directory ([mypeopleshealthplan.com](http://mypeopleshealthplan.com)) to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at [mypeopleshealthplan.com](http://mypeopleshealthplan.com).
- Call Customer Service at 1-877-367-1803 (TTY users call 711) to get current pharmacy information or to ask us to mail you a Pharmacy Directory.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-877-367-1803 (TTY users call 711) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

The amount you pay for Medicare-covered services depends on your level of Medicaid eligibility:

- If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, you pay a \$0 copayment for your Medicare cost sharing.
- If you are not a QMB or you don't have full Medicaid benefits, you must pay your Medicare cost sharing.

Medicare cost sharing includes copayments, coinsurance, and deductibles. If you don't have Extra Help, you're responsible for all Part D cost sharing amounts. Contact Louisiana Department of Health (Medicaid) at 1-225-342-9500 for more details.

The healthy food benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as high blood pressure, high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Contact us for details.

|                                                                 | 2026 (this year)                                                                                                                                                                                                                                                                                                                                             | 2027 (next year)                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture for chronic low back pain (Medicare-covered)</b> | <p>You pay 20% of the total cost for services provided by a primary care physician.</p> <p>You pay 20% of the total cost for services provided by a specialist.</p> <p>Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.</p> <p>See Chapter 4 of the Evidence of Coverage for details.</p> | <p>You pay a \$0 copayment for services provided by a primary care physician.</p> <p>You pay a \$10 copayment for services provided by a specialist.</p> <p>Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.</p> <p>See Chapter 4 of the Evidence of Coverage for details.</p> |
| <b>Additional routine foot care</b>                             | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                                                                     | Not covered.                                                                                                                                                                                                                                                                                                                                      |
| <b>Ambulance services</b>                                       | You pay 20% of the total cost for each one-way                                                                                                                                                                                                                                                                                                               | You pay a \$350 copayment for each one-                                                                                                                                                                                                                                                                                                           |

|                                                               | 2026 (this year)                                                                                                                                                                                       | 2027 (next year)                                                                                                                                         |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               | <p>Medicare-covered ground trip.</p> <p>You pay 20% of the total cost for each one-way Medicare-covered air trip.</p>                                                                                  | <p>way Medicare-covered ground trip.</p> <p>You pay a \$350 copayment for each one-way Medicare-covered air trip.</p>                                    |
| <b>Annual medical deductible</b>                              | For 2026, your plan has a \$283 deductible. The deductible does not apply to insulin furnished through durable medical equipment (DME). Please see Chapter 4 of your Evidence of Coverage for details. | For 2027, your plan does not have a deductible.                                                                                                          |
| <b>Blood</b>                                                  | You pay 20% of the total cost.                                                                                                                                                                         | You pay a \$0 copayment.                                                                                                                                 |
| <b>Cardiac rehabilitation</b>                                 | You pay 20% of the total cost.                                                                                                                                                                         | You pay a \$0 copayment.                                                                                                                                 |
| <b>Cardiac rehabilitation - intensive</b>                     | You pay 20% of the total cost.                                                                                                                                                                         | You pay a \$0 copayment.                                                                                                                                 |
| <b>Chiropractic services</b>                                  | You pay 20% of the total cost.                                                                                                                                                                         | You pay a \$0 copayment.                                                                                                                                 |
| <b>Dental Services (Medicare-covered)</b>                     | You pay 20% of the total cost.                                                                                                                                                                         | You pay a \$0 copayment.                                                                                                                                 |
| <b>Dental services</b><br>Comprehensive and preventive dental | <p>You pay a \$0 copayment for covered preventive and diagnostic services.</p> <p>You pay a \$0 copayment for covered comprehensive dental services.</p>                                               | <p>You pay a \$0 copayment for covered preventive and diagnostic services.</p> <p>You pay 50% coinsurance for covered comprehensive dental services.</p> |

|                                                                                              | 2026 (this year)                                                                                                                                                                                                                                                                                                     | 2027 (next year)                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                              | <p>You are covered for up to \$2,000 per year. Benefit is combined in and out-of-network.</p> <p>You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as \$0 copayment.</p> | <p>You are covered for up to \$3,000 per year. Benefit is combined in and out-of-network.</p> <p>You may receive dental services from an out-of-network dentist. If an out-of-network dentist charges more than your plan pays, you may be billed for the difference, even for services listed as \$0 copayment.</p> |
| <b>Diabetes self-management training, diabetic services and supplies - therapeutic shoes</b> | You pay 20% of the total cost.                                                                                                                                                                                                                                                                                       | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                             |
| <b>Durable medical equipment and related supplies</b>                                        | You pay 20% of the total cost.                                                                                                                                                                                                                                                                                       | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                             |
| <b>Emergency care</b>                                                                        | You pay a \$115 copayment.                                                                                                                                                                                                                                                                                           | You pay a \$130 copayment.                                                                                                                                                                                                                                                                                           |
| <b>Emergency care – worldwide</b>                                                            | Covered                                                                                                                                                                                                                                                                                                              | <p>Emergency care, including emergency ambulance services, outside of the United States and its territories is not covered by Original Medicare or the Plan.</p> <p>If you are travelling outside of the United States, you may wish to consider purchasing a separate Travel Medical Insurance policy.</p>          |

|                                                                       | 2026 (this year)                                                                                                                                                                                                                                                                                               | 2027 (next year)                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fitness program</b>                                                | <p>You have access to a fitness program for body and mind to help you stay active, focused and connected either at a gym or from home.</p> <p>You pay a \$0 copayment.</p> <p>There are no fees for standard membership services when you use network providers.</p>                                           | <p>You have access to a fitness program to help you stay active at a gym.</p> <p>You pay a \$0 copayment.</p> <p>There are no fees for standard membership services when you use network providers.</p> <p>Digital fitness, memory fitness and mail-order kits are no longer covered.</p> <p>View your Evidence of Coverage for more information.</p> |
| <b>Hearing services</b><br>Medicare-covered hearing and balance exams | You pay 20% of the total cost.                                                                                                                                                                                                                                                                                 | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                                                              |
| <b>Hearing services</b><br>Hearing aids                               | <p>You receive a \$1,500 allowance for up to 2 OTC or prescription hearing aids every 2 years.</p> <p>You pay a \$0 copayment.</p> <p>Home-delivered hearing aids are available nationwide through network providers (select products only).</p> <p>You must use network providers to access this benefit.</p> | <p>You receive a \$1,000 allowance for up to 2 prescription hearing aids every year.</p> <p>You pay a \$0 copayment.</p> <p>You must use network providers to access this benefit.</p> <p>Over-the-counter (OTC) hearing aids and home-delivered hearing aids are no longer covered.</p>                                                              |
| <b>Inpatient hospital care</b>                                        | You pay a \$1,970 copayment for each Medicare-covered                                                                                                                                                                                                                                                          | You pay a \$195 copayment each day for days 1 to 10.                                                                                                                                                                                                                                                                                                  |

|                                                                                                                                                           | 2026 (this year)                                                                                             | 2027 (next year)                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
|                                                                                                                                                           | hospital stay for unlimited days.                                                                            | \$0 copayment for additional Medicare covered days.                                               |
| <b>Inpatient mental health care</b>                                                                                                                       | You pay a \$1,970 copayment for each Medicare-covered hospital stay.                                         | You pay a \$195 copayment each day for days 1 to 10.<br>\$0 copayment each day for days 11 to 90. |
| <b>Outpatient diagnostic tests and therapeutic services and supplies – medical supplies</b>                                                               | You pay 20% of the total cost.                                                                               | You pay a \$0 copayment.                                                                          |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - X-rays</b>                                                                         | You pay 20% of the total cost.                                                                               | You pay a \$30 copayment.                                                                         |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - non-radiological diagnostic services</b>                  | You pay 20% of the total cost                                                                                | You pay a \$50 copayment.                                                                         |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - radiological diagnostic service, not including X-rays</b> | You pay a \$0 copayment for each diagnostic mammogram.<br>You pay 20% of the total cost otherwise otherwise. | You pay a \$0 copayment for each diagnostic mammogram.<br>You pay a \$320 copayment otherwise.    |
| <b>Outpatient dialysis treatment</b>                                                                                                                      | You pay a 20% of the total cost.                                                                             | You pay a \$0 copayment.                                                                          |
| <b>Outpatient mental health care - group therapy session</b>                                                                                              | You pay 20% of the total cost.                                                                               | You pay a \$15 copayment.                                                                         |
| <b>Outpatient mental health care - individual therapy session</b>                                                                                         | You pay 20% of the total cost.                                                                               | You pay a \$25 copayment.                                                                         |

|                                                                                                                                                                                                                               | 2026 (this year)                                                                                                                                                                           | 2027 (next year)                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Outpatient rehabilitation services - occupational therapy</b>                                                                                                                                                              | You pay 20% of the total cost.                                                                                                                                                             | You pay a \$10 copayment.                                                                                                                                                                  |
| <b>Outpatient rehabilitation services - physical therapy and speech therapy</b>                                                                                                                                               | You pay 20% of the total cost.                                                                                                                                                             | You pay a \$10 copayment.                                                                                                                                                                  |
| <b>Outpatient substance use disorder services - group therapy sessions</b>                                                                                                                                                    | You pay 20% of the total cost.                                                                                                                                                             | You pay a \$15 copayment.                                                                                                                                                                  |
| <b>Outpatient substance use disorder services - individual therapy sessions</b>                                                                                                                                               | You pay 20% of the total cost.                                                                                                                                                             | You pay a \$25 copayment.                                                                                                                                                                  |
| <b>Outpatient surgery - ambulatory surgical center</b>                                                                                                                                                                        | You pay a \$0 copayment for a diagnostic colonoscopy.<br>You pay 20% of the total cost otherwise.                                                                                          | You pay a \$0 copayment for a diagnostic colonoscopy.<br>You pay a \$195 copayment otherwise.                                                                                              |
| <b>Outpatient surgery - hospital outpatient facilities</b>                                                                                                                                                                    | You pay a \$0 copayment for a diagnostic colonoscopy.<br>You pay 20% of the total cost otherwise.                                                                                          | You pay a \$0 copayment for a diagnostic colonoscopy.<br>You pay a \$195 copayment otherwise.                                                                                              |
| <b>Outpatient surgery - hospital outpatient observation services</b>                                                                                                                                                          | You pay 20% of the total cost.                                                                                                                                                             | You pay a \$195 copayment.                                                                                                                                                                 |
| <b>OTC, home and bath safety devices, fitness, in-home support services, caregiver support, and weight management credit</b><br><br><b>Healthy food and utilities - Special Supplemental Benefits for the Chronically III</b> | \$200 credit a month loaded to your UnitedHealthcare UCard® for covered OTC products, home and bath safety devices, select fitness equipment and wearables, and extra support with in-home | \$182 credit a month loaded to your UnitedHealthcare UCard® for covered OTC products, home and bath safety devices, select fitness equipment and wearables, and extra support with in-home |

|  | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>services, respite care and weight management.</p> <p>If you qualify, you can also use your credits to pay for healthy food and certain utility bills.</p> <p>The healthy food and utility bills options are provided through the Special Supplemental Benefits for the Chronically Ill (SSBCI).</p> <p>These options are only available to chronically ill enrollees with a qualifying condition, such as chronic high blood pressure, chronic high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders – and more complex health needs.</p> <p>There may be other qualifying conditions not listed.</p> <p>You pay a \$0 copayment.</p> <p>Your credit amount expires at the end of each month.</p> | <p>services, respite care and weight management.</p> <p>If you qualify, you can also use your credits to pay for healthy food and certain utility bills.</p> <p>The healthy food and utility bills options are provided through the Special Supplemental Benefits for the Chronically Ill (SSBCI).</p> <p>These options are only available to chronically ill enrollees with a qualifying condition, such as chronic high blood pressure, chronic high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders – and more complex health needs.</p> <p>There may be other qualifying conditions not listed.</p> <p>We'll send you a letter with information about your eligibility for SSBCI benefits.</p> <p>You pay a \$0 copayment.</p> <p>Your credit amount expires at the end of each month.</p> <p>You can use your current UCard through Dec.31, 2026.</p> |

|                                                                                                                       | 2026 (this year)                                  | 2027 (next year)                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                       |                                                   | <p>We'll mail you a new UCard before the new plan year begins.</p> <p>Visit <a href="https://member.uhc.com/uhc/benefits/ssbci">member.uhc.com/uhc/benefits/ssbci</a> or view your Evidence of Coverage after Oct. 1, 2026, for more information.</p> |
| <b>Partial hospitalization and intensive outpatient services</b>                                                      | You pay a \$55 copayment.                         | You pay a \$10 copayment.                                                                                                                                                                                                                             |
| <b>Physician/practitioner services, including doctor's office visits - Medicare-covered hearing and balance exams</b> | You pay 20% of the total cost.                    | You pay a \$0 copayment.                                                                                                                                                                                                                              |
| <b>Physician/practitioner services, including doctor's office visits - primary care provider</b>                      | You pay 20% of the total cost.                    | You pay a \$0 copayment.                                                                                                                                                                                                                              |
| <b>Physician/practitioner services, including doctor's office visits - specialists</b>                                | You pay 20% of the total cost.                    | You pay a \$10 copayment.                                                                                                                                                                                                                             |
| <b>Podiatry services (Medicare-covered)</b>                                                                           | You pay 20% of the total cost.                    | You pay a \$10 copayment.                                                                                                                                                                                                                             |
| <b>Prostate cancer screening exams – digital rectal exams</b>                                                         | You pay 20% of the total cost.                    | You pay a \$0 copayment                                                                                                                                                                                                                               |
| <b>Prosthetic devices and related supplies</b>                                                                        | You pay 20% of the total cost.                    | You pay a \$0 copayment.                                                                                                                                                                                                                              |
| <b>Pulmonary rehabilitation</b>                                                                                       | You pay 20% of the total cost.                    | You pay a \$0 copayment.                                                                                                                                                                                                                              |
| <b>Referral</b>                                                                                                       | Some network services—like visits to specialists, | Physical therapy, speech therapy, and occupational                                                                                                                                                                                                    |

|                                             | 2026 (this year)                                                                                                                                                                                                                                                                                        | 2027 (next year)                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                             | <p>physical therapy, speech therapy, and occupational therapy—will require a referral from your primary care provider (PCP) in order to be covered. The PCP you choose will impact which specialists and hospitals you'll be able to see.</p> <p>Review your Evidence of Coverage for more details.</p> | <p>therapy no longer require referrals.</p> <p>Only visits to specialists will require a referral from your primary care provider (PCP) in order to be covered. The PCP you choose can impact which specialists and hospitals you'll be able to see.</p> <p>For more information, view Chapter 3 Section 2.2 of the Evidence of Coverage.</p> |
| <b>Skilled nursing facility (SNF) care</b>  | <p>You pay the Original Medicare cost sharing amount for skilled nursing services.</p> <p>\$0 copayment each day for days 1 to 20.</p> <p>\$217 copayment each day for days 21 to 100 .</p>                                                                                                             | <p>You pay a \$0 copayment each day for days 1 to 20.</p> <p>You pay a \$100 copayment each day for days 21 to 100.</p>                                                                                                                                                                                                                       |
| <b>Supervised exercise therapy (SET)</b>    | You pay 20% of the total cost.                                                                                                                                                                                                                                                                          | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                                                      |
| <b>Transportation (additional routine)</b>  | <p>Get up to 36 one-way trips to or from plan-approved locations, such as medically related appointments, the pharmacy and certain other locations that help you use your benefits.</p> <p>You pay a \$0 copayment.</p>                                                                                 | <p>Get up to 24 one-way trips to or from plan-approved locations, such as medically related appointments, the pharmacy and certain other locations that help you use your benefits.</p> <p>You pay a \$0 copayment.</p>                                                                                                                       |
| <b>Urgently needed services – worldwide</b> | Covered                                                                                                                                                                                                                                                                                                 | Urgently Needed Services outside of the United States and its territories                                                                                                                                                                                                                                                                     |

|                                                                             | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                            | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>are not covered by Original Medicare or the Plan.</p> <p>If you are traveling outside of the United States, you may wish to consider purchasing a separate Travel Medical Insurance policy.</p>                                                                                                                                                                                                                                                |
| <b>Urgently needed services</b>                                             | You pay a \$40 copayment for each visit.                                                                                                                                                                                                                                                                                                                                                                                                    | You pay a \$50 copayment for each visit.                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Vision care</b><br>Additional routine eyewear                            | <p>You pay a \$0 copayment for standard lenses and receive up to \$250 toward your purchase of frames or contact lenses every year.</p> <p>Limited to 1 pair of standard lenses and frames or contact lenses every year.</p> <p>Home-delivered eyewear is available nationwide through network providers (select products only).</p> <p>You are responsible for all costs for eyewear not purchased from a UHC Vision network provider.</p> | <p>Receive a total credit of \$300 toward your purchase of 1 pair of frames/lenses or contact lenses every 2 years.</p> <p>Limited to 1 pair of frames/lenses or contact lenses every 2 years.</p> <p>You pay a \$0 copayment.</p> <p>Home-delivered eyewear is available nationwide through network providers (select products only).</p> <p>You are responsible for all costs for eyewear not purchased from a UHC Vision network provider.</p> |
| <b>“Welcome to Medicare” preventive visit - EKG following welcome visit</b> | You pay 20% of the total cost.                                                                                                                                                                                                                                                                                                                                                                                                              | You pay a \$0 copayment.                                                                                                                                                                                                                                                                                                                                                                                                                          |

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## Section 1.6 Changes to Part D Drug Coverage

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### Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. **You can get the complete Drug List** by calling Customer Service at 1-877-367-1803 (TTY users call 711) or visiting our website ([mypeopleshealthplan.com](http://mypeopleshealthplan.com)). This material will be available online after **October 15, 2026**.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your Evidence of Coverage and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. Call Customer Service at 1-877-367-1803 (TTY users call 711) for more information.

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## Section 1.7 Changes to Prescription Drug Benefits & Costs

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### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells you about your drug costs. If you get Extra Help, you will receive a LIS Rider. If you don't get this material, call Customer Service at 1-877-367-1803 (TTY users call 711) and ask for the LIS Rider to be sent to you.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date out-of-pocket costs reach \$2,400.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

**Drug Costs in Stage 1: Yearly Deductible**

The table shows your cost per prescription during this stage.

|                          | 2026 (this year)                                                                                                                                                                                                                                                                                                                                                                                                                   | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | <p>\$0</p> <p>(Look at the separate insert, the LIS Rider, for your deductible amount.)</p> <p>If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs:</p> <p>\$615</p> <p>During this stage, you pay \$0 for drugs on Tier 1 (in-network standard retail 30-day supply), and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you've reached the yearly deductible.</p> | <p>\$0</p> <p>(Look at the separate insert, the LIS Rider, for your deductible amount.)</p> <p>If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs:</p> <p>\$700</p> <p>During this stage, you pay \$0 for drugs on Tier 1 (in-network standard retail 30-day supply), and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you've reached the yearly deductible.</p> |

**Drug Costs in Stage 2: Initial Coverage**

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 2, Tier 3, Tier 4 and Tier 5 drugs. For example, if your coinsurance is 25% and the total cost of your prescription is \$100, you would pay \$25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your **Evidence of Coverage**.

Once you've paid \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                                                 | 2026 (this year)                                                                                                                                                                             | 2027 (next year)                                                                                                                                                                             |
|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                 | <b>If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs</b>                                                                                           |                                                                                                                                                                                              |
| <b>Generic drugs (including brand drugs treated as generic)</b> | For generic drugs (including brand drugs treated as generic) <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$1.60 copayment or</li> <li>• \$5.10 copayment</li> </ul> | For generic drugs (including brand drugs treated as generic) <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$1.65 copayment or</li> <li>• \$5.80 copayment</li> </ul> |
| <b>For all other covered drugs</b>                              | For all other covered drugs: <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$4.90 copayment or</li> <li>• \$12.65 copayment</li> </ul>                                | For all other covered drugs: <ul style="list-style-type: none"> <li>• \$0 copayment or</li> <li>• \$5 copayment or</li> <li>• \$14.40 copayment</li> </ul>                                   |
|                                                                 | <b>If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs</b>                                                                                       |                                                                                                                                                                                              |
| <b>Tier 1 - Preferred Generic</b>                               | You pay \$0 per prescription.                                                                                                                                                                | You pay \$0 per prescription.                                                                                                                                                                |
| <b>Tier 2 - Generic</b>                                         | You pay 25% of the total cost.                                                                                                                                                               | You pay 25% of the total cost.                                                                                                                                                               |
| <b>Tier 3 - Preferred Brand</b>                                 | You pay 25% of the total cost.<br>You pay 25%, up to \$35 per month supply of each covered insulin product on this tier <sup>1</sup> .                                                       | You pay 25% of the total cost.<br>You pay 25%, up to \$35 per month supply of each covered insulin product on this tier <sup>1</sup> .                                                       |
| <b>Tier 4 - Non-Preferred Drug</b>                              | You pay 25% of the total cost.                                                                                                                                                               | You pay 25% of the total cost.                                                                                                                                                               |
| <b>Tier 5 - Specialty Tier</b>                                  | You pay 25% of the total cost.                                                                                                                                                               | You pay 25% of the total cost.                                                                                                                                                               |

<sup>1</sup> In 2026, you pay no more than \$35 for each 1-month supply of Part D covered insulin drugs. In 2027, you'll pay no more than a \$35 copay or 25% of the total drug cost—whichever is less—until

you reach the Catastrophic Coverage stage where your cost drops to \$0. You pay these amounts even if you haven't paid your deductible.

## Section 2 Administrative Changes

|                                                                                       | 2026 (this year)                                                                                       | 2027 (next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization - Comprehensive Dental Services</b>                            | Your provider may need to request prior authorization.                                                 | Your provider no longer needs to request prior authorization.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization - Meal benefit following a covered inpatient hospital stay</b> | Prior authorization is required in addition to verification of a qualifying stay.                      | Prior authorization is no longer required. The plan will continue to confirm eligible stays before we send your order.                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>UnitedHealthcare UCard and member ID card</b>                                      | The UCard serves as your member ID card and more – use it to spend your OTC credits on eligible items. | <p>You'll get 2 cards in separate mailings - a member ID card and a UCard.</p> <p>Use your new member ID card when visiting a provider or filling a prescription.</p> <p>Use your UCard as payment in-store or online to spend your OTC credits on eligible items. UCards expire after 3 years, which means you won't get a new UCard every year. You can destroy your current card Jan. 1, 2027.</p> <p>To check your balance, find participating stores and eligible items, visit the UCard Hub on the UnitedHealthcare app or your member site.</p> |

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## Section 3      How to Change Plans

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**To stay in our plan, you don't need to do anything.** Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Peoples Health Secure Health (HMO-POS D-SNP).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Peoples Health Secure Health (HMO-POS D-SNP). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from Peoples Health Secure Health (HMO-POS D-SNP).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll or visit our website to disenroll online ([mypeopleshealthplan.com](https://mypeopleshealthplan.com)). Call Customer Service at 1-877-367-1803 (TTY users call 711) for more information on how to do this. Or call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty.
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.medicare.gov), check the **Medicare & You 2027 handbook**, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE. As a reminder, UnitedHealthcare Insurance Company or one of its affiliates offers other Medicare health plans AND/OR Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

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### Section 3.1      Deadlines for Changing Plans

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People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

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### Section 3.2      Are there other times of the year to make a change?

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In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare with a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## Section 4      Get Help Paying for Prescription Drugs

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You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week;
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** Louisiana has a program called Louisiana Department of Health that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs

that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP in your state. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you're currently enrolled, how to continue getting help, call the ADAP in your state. You can find your state's ADAP contact information in Chapter 2 of the **Evidence of Coverage**. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027. You do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**
- Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-877-367-1803 (TTY users call 711) or visit Medicare.gov.

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## Section 5      Questions?

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### Get Help from Peoples Health Secure Health (HMO-POS D-SNP)

- **Call Customer Service at 1-877-367-1803. (TTY users call 711).**

We're available for phone calls 8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept. Calls to these numbers are free.

- **Read your 2027 Evidence of Coverage**

This **Annual Notice of Change** gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 **Evidence of Coverage** for Peoples Health Secure Health (HMO-POS D-SNP). The **Evidence of Coverage** is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the **Evidence of Coverage** on our website at [mypeopleshealthplan.com](http://mypeopleshealthplan.com) or call Customer Service at 1-877-367-1803 (TTY users call 711) to ask us to mail you a copy.

- **Visit [mypeopleshealthplan.com](http://mypeopleshealthplan.com)**

Our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (formulary/drug list). The Provider Directory and Formulary will be available after **October 15, 2026**.

**Get Free Counseling about Medicare**

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Louisiana, the SHIP is called Louisiana Senior Health Insurance Information Program (SHIIP).

Call Louisiana Senior Health Insurance Information Program (SHIIP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Louisiana Senior Health Insurance Information Program (SHIIP) at 1-800-259-5300.

**Get Help from Medicare**

- **Call 1-800-MEDICARE (1-800-633-4227)**

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

- **Chat live with Medicare.gov**

You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read Medicare & You 2027**

The Medicare & You 2027 handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**Get Help from Medicaid**

Call Louisiana Department of Health (Medicaid) at 1-225-342-9500. TTY users can call 711 for help with Medicaid enrollment or benefit questions.

## Notice of availability of language assistance services and alternate formats

**ATTENTION:** Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ملاحظة: إذا كنت تتحدث اللغة العربية (Arabic)، ستثوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتأسيقات أخرى، مثل الطباعة بأحرف كبيرة. ائصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

দেখুন: আপনি যদি বাংলায় (Bengali) কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন।

請注意：如果您說中文 (Chinese)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

توجه: اگر په ږېان فارسي (Farsi) صحېتې مې ګڼېد، خدمات ږېان ګان کمک ږېانې و اړتياوات ږېان ګان درې ګالپه ګان ډېګر، مانېد چاپ ږېرګ، در دسترس شما هستېد. پا شمارة ږېان ګان مندرج روی کارټ شناسايي عضویت ټان تماس ګیرېد.

**ATTENTION :** Si vous parlez français (French), des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કોલ કરો.

**ATANSYON:** Si w pale Kreyòl Ayisyen (Haitian Creole), gen sèvis lang gratis ak kominikasyon nan lòt fòm lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

**알림 사항:** 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

**ATENÇÃO:** se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

**ВНИМАНИЕ!** Если вы говорите на **русском языке (Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

**PAUNAWA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

**โปรดทราบ** หากคุณพูดภาษาไทย (Thai) ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

**توجہ دیں:** اگر آپ اردو (Urdu) زبان بولتے ہیں تو زبان کی معاون خدمات اور دیگر فارمیٹس میں مواصلات، جیسے بڑے پرنٹ، آپ کے لیے مفت دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

**LƯU Ý:** Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

## Notice of nondiscrimination

Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member identification card (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130  
**UHC\_Civil\_Rights@uhc.com**

Optum Civil Rights Coordinator  
1 Optum Circle  
Eden Prairie, MN 55344  
**Optum\_Civil\_Rights@Optum.com**

If you need help filing a complaint, call the toll-free number on your member identification card (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**

Phone: **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

Complaint forms are available at: **<http://www.hhs.gov/ocr/office/file/index.html>**.

This notice is available at: **<https://www.uhc.com/nondiscrimination-med>**  
**<https://www.optum.com/en/language-assistance-nondiscrimination.html>**

# Peoples Health Secure Health (HMO-POS D-SNP)

## Customer Service:



Download the **UnitedHealthcare app**



Visit **[mypeopleshealthplan.com](https://mypeopleshealthplan.com)**



Call **1-877-367-1803**

Calls to this number are free. 8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept.  
Customer Service also has free language interpreter services available for non-English speakers.

**TTY 711**

Calls to this number are free.  
8 a.m.-8 p.m. local time, 7 Days Oct-Mar, M-F Apr-Sept.



Write: **P.O. Box 30770**  
**Salt Lake City, UT 84130-0770**

### Do we have the right address for you?

If not, please let us know so we can keep you informed about your plan.