


Peoples Health Patriot (PPO) | 2023

Plan ID card:

		Peoples Health Patriot (PPO) <small>With UnitedHealthcare Dental</small>	
John H Smith RxID/Policy # G0000000000 Plan (80840) PCP Name Mary Bird Perkins		Part B Drugs RxBin 610494 RxPCN 9999 RxGroup MPDPPH <small>MEDICARE LIMITING CHARGES APPLY</small>	
In Network: PCP: \$0 ER: \$90 Out of Network: PCP: \$20	Spec: \$30 Urgent: \$40 Spec: \$50	H4544-002-000	

For Members: Member Website: mypeopleshealth.com Member Services: 1-800-222-8600 (TTY: 711) NurseLine: 1-877-365-7949 (TTY: 711) Behavioral Health: 1-877-566-7913 (TTY: 711)			
For Providers: Provider Portal: peopleshealth.com/providerportal Medical Providers Direct Questions To: 1-866-559-5705 Pharmacists Direct Questions To: 1-877-889-6510 Medical Electronic Claim: Change Healthcare Payer ID: 72126 Medical Claim Address: P.O. Box 981645, El Paso, TX 79998-1645 Issue Date: MM/DD/YYYY			

Note: Peoples Health members will have an ID card with a contract number at the bottom right, and RxBin number 610494, RxPCN 9999, and RxGroup MPDPPH. The card shows select 2023 cost-sharing on the front and includes important phone numbers on the back.
This plan only has Part B drug coverage and does not offer Part D prescription drug coverage.

IMPORTANT NOTICE
 Always verify eligibility prior to rendering services.

Peoples Health Patriot (PPO)	2023 In-Network Benefits	2023 Out-of-Network Benefits
Benefit Description	In-Network Cost-Sharing Amounts	Out-of-Network Cost-Sharing Amounts
Out-of-Pocket Maximum	\$5,900 for Medicare-covered benefits	Combined maximum of \$8,950 for Medicare-covered benefits received in and out of network
INPATIENT CARE		
Inpatient Hospital Care	\$195 (days 1-6) \$0 (days 7 and beyond)	30% coinsurance for each admission
Inpatient Mental Health Care	\$195 (days 1-6) \$0 (days 7 and beyond)	30% coinsurance for each admission
Skilled Nursing Facility Care	\$0 (days 1-20) \$196 (days 21-51) \$0 (days 52-100) 100-day max per benefit period	\$225 (days 1-40) \$0 (days 41-100) 100-day max per benefit period
Home Health Care	\$0	50% coinsurance
Meals After Inpatient Hospital Stay	\$0 for 28 meals over 14 days; meals not covered following discharge from inpatient mental health stay, SNF stay or observation stay; meals are delivered to the patient's home through the network meal provider	
AMBULANCE SERVICES		
Ambulance Services	\$250 each way	\$250 each way
OUTPATIENT CARE		
PCP Office Visit	\$0	\$20
Specialist Office Visit	\$30	\$50
Medicare-Covered Podiatry Services	\$30	\$50
Routine Foot Care	\$30 per visit; up to 6 visits per year	\$50 per visit; up to 6 visits per year
Chiropractic Services	\$20	\$50
Acupuncture for Chronic Low Back Pain	Cost-sharing for primary care visit or specialist visit, depending on where services are received	Cost-sharing for primary care visit or specialist visit, depending on where services are received
Medicare-Covered Diagnostic Colonoscopy	\$0	30% coinsurance
Medicare-Covered Diagnostic Mammogram	\$0	30% coinsurance
Diagnostic Procedures and Tests (non-radiological)*	\$20	30% coinsurance
X-rays*	\$15	\$20
Advanced Imaging (MRI, MRA, CT, CTA and PET scans)	\$110	30% coinsurance
Therapeutic Radiological Services (radiation therapy)	\$50	30% coinsurance
Lab Services*	\$0	\$0
Outpatient Mental Health Care Services	\$25 for each individual session; \$15 for each group session Services must be arranged by a network behavioral health provider	\$40 for each individual session; \$30 for each group session
Outpatient Substance Abuse	\$25 for each individual session; \$15 for each group session Services must be arranged by a network behavioral health provider	\$40 for each individual session; \$30 for each group session
Partial Hospitalization	\$55; services must be arranged by a network behavioral health provider	\$75
Outpatient Rehabilitation Services (occupational, physical and speech therapy)	\$30	\$50
Cardiac Rehabilitation Services	\$0	\$50
Pulmonary Rehabilitation Services	\$20	\$50
Outpatient Hospital Services	\$195 for outpatient hospital services, including observation visits, at an outpatient hospital	30% coinsurance
Outpatient Surgery	\$195	30% coinsurance
Durable Medical Equipment	20% coinsurance	50% coinsurance
Prosthetic Devices (including replacements and repairs)	20% coinsurance	50% coinsurance
Medical Supplies	20% coinsurance	50% coinsurance
Diabetes Supplies and Services	\$0 for Medicare-covered diabetes supplies and continuous glucose monitors 20% coinsurance for Medicare-covered therapeutic shoes Approved brands of diabetes monitoring supplies available at a retail pharmacy	50% coinsurance; approved brands of diabetes monitoring supplies available at a retail pharmacy
Dialysis Services	20% coinsurance	20% coinsurance
EMERGENCY AND URGENTLY NEEDED CARE		
Emergency Care (copay waived if admitted to an inpatient stay within 24 hours for the same condition)	\$90 within the U.S.; \$0 outside of the U.S. or its territories	
Urgently Needed Care	\$40 within the U.S.; \$0 outside of the U.S. or its territories	
ADDITIONAL BENEFITS		
Dental Services	20% coinsurance for Medicare-covered comprehensive dental \$0 for preventive and comprehensive dental services \$2,500 combined max benefit amount for services received in and out of network	30% coinsurance for Medicare-covered comprehensive dental \$0 for preventive and comprehensive dental services (costs from an out-of-network dentist may be higher)
Vision Services	\$0 for Medicare-covered exams and services to diagnose and treat diseases/conditions of the eye \$0 for one routine eye exam per year \$200 allowance for eyeglass frames and lenses or contact lenses; patient must use a UnitedHealthcare Vision provider	\$50 for Medicare-covered exams and services to diagnose and treat diseases/conditions of the eye \$50 for one routine eye exam per year
Hearing Services	\$0 for Medicare-covered diagnostic hearing exams \$0 for one routine hearing exam per year \$175-\$1,225 for each hearing aid (two covered per year); patient must use a UnitedHealthcare Hearing provider	\$50 for Medicare-covered diagnostic hearing exams \$50 for one routine hearing exam per year
Fitness Benefit	\$0 through network providers	
Over-the-Counter Items	\$75 quarterly allowance for over-the-counter health and wellness items from network OTC provider	
Respite Care	Not covered	
Opioid Treatment	\$0 for Medicare-covered opioid treatment program services	
Virtual Visits	\$0 for primary care, urgently needed care, specialist care and other types of care through a provider offering virtual visits; see <i>Evidence of Coverage</i> for complete details	Primary care, urgently needed care and specialist care not covered through a provider offering virtual visits 30% coinsurance for other types of care through a provider offering virtual visits
Virtual Mental Health Visits	\$0 through network provider, Optum Behavioral Health	
NurseLine (1-877-365-7949)	\$0	
Personal Emergency Response System	\$0 through network provider	
PHARMACY COVERAGE (PART B)		
Part B Rx	\$0 for Part B allergy antigens 20% coinsurance for all other Part B drugs	\$0 for Part B allergy antigens 30% coinsurance for all other Part B drugs
Chemotherapy Drugs	20% coinsurance	
Home Infusion Therapy	Cost-sharing for primary care physician visit, specialist visit or home health, depending on where services are received	
PHARMACY COVERAGE (PART D)		
This plan does not cover Part D prescription drugs.		
*Patient also pays the office visit copay when service is received at a physician's office.		
Some services require prior authorization. Authorization is not a guarantee of payment, as services must be medically necessary. Use the Peoples Health Authorization Requirements Search to identify authorization requirements for procedure codes by place of service.		
Out-of-network providers must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. Patients may be responsible for the full cost of the services if the provider does not participate in Medicare. Patients should confirm the provider participates in Medicare prior to receiving services.		