PEOPLES HEALTH

2017

Peoples Health **Choices Select (HMO)** offered by Peoples Health Annual Notice of Changes for 2017

You are currently enrolled as a member of Peoples Health Choices Select. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

Additional Resources

- Member services has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This document may be made available in alternate formats.
- Minimum essential coverage (MEC): Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About Peoples Health Choices Select

- Peoples Health is a Medicare Advantage organization with a Medicare contract to offer HMO plans. Enrollment depends on annual Medicare contract renewal.
- When this booklet says "we," "us," or "our," it means Peoples Health. When it says "plan" or "our plan," it means Peoples Health Choices Select.

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(Approved 03/2014)

OMB Approval 0938-1051

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.5 and 2 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our *Provider Directory*.
- ☐ **Think about your overall healthcare costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Peoples Health Choices Select:

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Peoples Health Choices Select in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$122.40	$65
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $5 per visit Specialist visits: $40 per visit	Primary care visits: $5 per visit Specialist visits: $40 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$150 per day for days 1-10; $0 per day for days 11 and beyond	$185 per day for days 1-10; $0 per day for days 11 and beyond
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayments/coinsurance during the Initial Coverage Stage:	Deductible: $0 Copayments/coinsurance during the Initial Coverage Stage:

Cost	2016 (this year)	2017 (next year)
	• Drug Tier 1: $0 for a 30-day supply from a preferred retail pharmacy and $3 for a 30-day supply from a standard retail pharmacy • Drug Tier 1: $0 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $9 for a 90-day supply from a standard retail or standard mail-order pharmacy • Drug Tier 2: $10 for a 30-day supply from a preferred retail pharmacy and $15 for a 30-day supply from a standard retail pharmacy • Drug Tier 2: $30 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $45 for a 90-day supply from a standard retail or standard mail-order pharmacy • Drug Tier 3: $37 for a 30-day supply from a preferred retail pharmacy and $47 for a 30-day supply from a standard retail pharmacy • Drug Tier 3: $111 for a 90-day supply from a preferred retail or	• Drug Tier 1: $0 for a 30-day supply from a preferred retail pharmacy and $3 for a 30-day supply from a standard retail pharmacy • Drug Tier 1: $0 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $9 for a 90-day supply from a standard retail or standard mail-order pharmacy • Drug Tier 2: $12 for a 30-day supply from a preferred retail pharmacy and $17 for a 30-day supply from a standard retail pharmacy • Drug Tier 2: $36 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $51 for a 90-day supply from a standard retail or standard mail-order pharmacy • Drug Tier 3: $37 for a 30-day supply from a preferred retail pharmacy and $47 for a 30-day supply from a standard retail pharmacy • Drug Tier 3: $111 for a 90-day supply from a preferred retail or

Cost	2016 (this year)	2017 (next year)
	preferred mail-order pharmacy and $141 for a 90-day supply from a standard retail or standard mail-order pharmacy	preferred mail-order pharmacy and $141 for a 90-day supply from a standard retail or standard mail-order pharmacy
	• Drug Tier 4: $85 for a 30-day supply from a preferred retail pharmacy and $95 for a 30-day supply from a standard retail pharmacy	• Drug Tier 4: $90 for a 30-day supply from a preferred retail pharmacy and $100 for a 30-day supply from a standard retail pharmacy
	• Drug Tier 4: $255 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $285 for a 90-day supply from a standard retail or standard mail-order pharmacy	• Drug Tier 4: $270 for a 90-day supply from a preferred retail or preferred mail-order pharmacy and $300 for a 90-day supply from a standard retail or standard mail-order pharmacy
	• Drug Tier 5: 33% coinsurance for a 30-day supply at a preferred or standard retail pharmacy	• Drug Tier 5: 33% coinsurance for a 30-day supply at a preferred or standard retail pharmacy
	• Drug Tier 5: 33% coinsurance for a 90-day supply at a preferred or standard retail or mail-order pharmacy	• Drug Tier 5: 33% coinsurance for a 90-day supply at a preferred or standard retail or mail-order pharmacy

Annual Notice of Changes for 2017
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$122.40	$65

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2017. An updated *Provider Directory* is located on our website at http://www.peopleshealth.com/searchtools. You may also call member services for updated provider information or to ask us to mail you a *Provider Directory*. **We strongly suggest that you review our current *Provider Directory* to see if your providers (primary care physician, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your healthcare needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may 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 includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year. An updated *Provider Directory* is located on our website at http://www.peopleshealth.com/searchtools. You may also call member services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2017 *Provider Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2017 Evidence of Coverage*.

Cost	2016 (this year)	2017 (next year)
Advanced imaging (e.g. MRI, MRA, PET, CT, and CTA scans) and nuclear medicine	You pay a $150 copayment for Medicare-covered advanced imaging services or nuclear medicine received at a network location.	You pay a $185 copayment for Medicare-covered advanced imaging services or nuclear medicine received at a network location.
Ambulance services	You pay a $200 copayment for each one-way Medicare-covered ambulance service.	You pay a $220 copayment for each one-way Medicare-covered ambulance service.
Emergency care	You pay a $50 copayment for each Medicare-covered emergency room visit in the United States or its territories. You pay a $50 copayment for each worldwide emergency room visit outside the United States or its territories.	You pay a $75 copayment for each Medicare-covered emergency room visit in the United States or it territories. You pay a $75 copayment for each worldwide emergency room visit outside the United States or its territories.

Cost	2016 (this year)	2017 (next year)
Inpatient hospital care	You pay a $150 copayment each day for days 1-10 for each inpatient admission to a network hospital or other network facility (including a long-term acute care facility or an inpatient rehabilitation facility) for Medicare-covered services. Out-of-pocket costs are limited to $1,500 for each inpatient admission.	You pay a $185 copayment each day for days 1-10 for each inpatient admission to a network hospital or other network facility (including a long-term acute care facility or an inpatient rehabilitation facility) for Medicare-covered services. Out-of-pocket costs are limited to $1,850 for each inpatient admission.
Inpatient mental health care	You pay a $150 copayment each day for days 1-10 for each inpatient admission to a network hospital or network psychiatric facility for Medicare-covered mental health services. Out-of-pocket costs are limited to $1,500 for each inpatient admission.	You pay a $155 copayment each day for days 1-10 for each inpatient admission to a network hospital or network psychiatric facility for Medicare-covered mental health services. Out-of-pocket costs are limited to $1,550 for each inpatient admission.
Inpatient services covered during a non-covered inpatient stay	You pay a $150 copayment each day for Medicare-covered inpatient services received during a non-covered inpatient stay at a network hospital or other network facility (including a long-term acute care facility or an inpatient rehabilitation facility).	You pay a $185 copayment each day for Medicare-covered inpatient services received during a non-covered inpatient stay at a network hospital or other network facility (including a long-term acute care facility or an inpatient rehabilitation facility).

Cost	2016 (this year)	2017 (next year)
Medicare Part B prescription drugs	You pay 15% of the total cost at a network provider for Medicare Part B-covered drugs (including chemotherapy drugs). You pay 15% of the total cost at a network provider for Medicare-covered infusion therapy other than home infusion therapy.	You pay 20% of the total cost at a network provider for Medicare Part B-covered drugs (including chemotherapy drugs). You pay 20% of the total cost at a network provider for Medicare-covered infusion therapy other than home infusion therapy.
Outpatient rehabilitation services	You pay a $10 copayment for each visit to a network outpatient facility for Medicare-covered occupational therapy, physical therapy, or speech language therapy services.	You pay a $15 copayment for each visit to a network outpatient facility for Medicare-covered occupational therapy, physical therapy, or speech language therapy services.
Outpatient surgery	You pay a $100 copayment for each Medicare-covered visit to a network ambulatory surgical center for outpatient surgery. You pay a $150 copayment for each Medicare-covered visit to a network outpatient hospital facility for outpatient surgery.	You pay a $150 copayment for each Medicare-covered visit to a network ambulatory surgical center for outpatient surgery. You pay a $200 copayment for each Medicare-covered visit to a network outpatient hospital facility for outpatient surgery.

Cost	2016 (this year)	2017 (next year)
Skilled nursing facility care	You pay a $150 copayment each day for days 21-100 for Medicare-covered skilled nursing care at a network Medicare-certified skilled nursing facility each benefit period.	You pay a $155 copayment each day for days 21-100 for Medicare-covered skilled nursing care at a network Medicare-certified skilled nursing facility each benefit period.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. The Drug List we included in this envelope includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling member services (see the back cover) or visiting our website (http://www.peopleshealth.com/formulary).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call member services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call member services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can

either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have a current formulary exception for a drug in 2016, you usually submit a new formulary exception request for that drug for 2017 if you need to continue taking it.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30, please call member services and ask for the "LIS Rider." Phone numbers for member services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below and on the following pages shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. 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.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (preferred generic tier):** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 (generic tier):** *Standard cost-sharing:* You pay $15 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 3 (preferred brand tier):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $37 per prescription. **Tier 4 (nonpreferred brand tier):** *Standard cost-sharing:* You pay $95 per prescription. *Preferred cost-sharing:* You pay $85 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (preferred generic tier):** *Standard cost-sharing:* You pay $3 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 (generic tier):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (preferred brand tier):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $37 per prescription. **Tier 4 (nonpreferred brand tier):** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $90 per prescription.

	2016 (this year)	2017 (next year)
	Tier 5 (specialty tier): *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 (specialty tier):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Other Changes

	2016 (this year)	2017 (next year)
Service Area	Our service area includes these parishes in Louisiana: Assumption, East Feliciana, Iberville, Lafourche, Pointe Coupee, St. Helena, St. Mary, Tangipahoa, Terrebonne, Washington, and West Feliciana.	Our service area includes these parishes in Louisiana: Tangipahoa and Washington.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Peoples Health Choices Select

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2017.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Peoples Health Choices Select.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Peoples Health Choices Select.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact member services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2017.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

SHIIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. SHIIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIIP at 1-800-259-5300. You can learn more about SHIIP by visiting their website (http://www.ldi.la.gov/SHIIP).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your state Medicaid office (applications);

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Louisiana Health Access Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 504-568-7474, Monday through Friday, from 8 a.m. to 5 p.m.

SECTION 7 Questions?

Section 7.1 – Getting Help from Peoples Health

Questions? We're here to help. Please call member services at 1-800-222-8600. (TTY only, call 1-800-846-5277). We are available for phone calls seven days a week, from 8 a.m. to 8 p.m. If you contact us on a weekend or holiday, you may need to leave a message, but we will return your call within one business day. Calls to these numbers are free.

Read your 2017 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2017. For details, look in the 2017 *Evidence of Coverage* for Peoples Health Choices Select. 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. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at http://www.peopleshealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly 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 should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on "Find health & drug plans").

Read *Medicare & You 2017*

You can read the *Medicare & You 2017* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

PEOPLES HEALTH

Multi-Language Insert

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-222-8600 (TTY: 1-800-846-5277).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-222-8600 (TTY: 1-800-846-5277).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-222-8600（TTY：1-800-846-5277）。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-222-8600 (TTY: 1-800-846-5277).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-222-8600 (ATS : 1-800-846-5277).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-222-8600 (TTY: 1-800-846-5277).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-222-8600 (TTY: 1-800-846-5277).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-222-8600 (TTY: 1-800-846-5277) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-222-8600 (телетайп: 1-800-846-5277).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-222-0068 (رقم هاتف الصم والبكم: 1-800-648-7725.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-222-8600 (TTY: 1-800-846-5277) पर कॉल करें।

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-222-8600 (TTY: 1-800-846-5277).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-222-8600 (TTY: 1-800-846-5277).

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French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-222-8600 (TTY: 1-800-846-5277).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-222-8600 (TTY: 1-800-846-5277).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-222-8600（TTY: 1-800-846-5277）まで、お電話にてご連絡ください。

Lao: ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການ ລວມການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍ ບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທ 1-800-222-8600 (TTY: 1-800-846-5277).

Urdu:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .1-800-222-8600 (TTY: 1-800-846-5277)

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-222-8600 (TTY: 1-800-846-5277) تماس بگیرید.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-222-8600 (TTY: 1-800-846-5277).

PEOPLES HEALTH

Notice of Nondiscrimination

Peoples Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Peoples Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Peoples Health:

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

If you need these services, contact Donna Klein, Peoples Health general counsel and civil rights coordinator.

If you believe that Peoples Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Donna Klein, Peoples Health general counsel and civil rights coordinator; Peoples Health, Three Lakeway Center, 3838 N. Causeway Blvd., Suite 2200, Metairie, LA 70002; 504-849-4500, ext. 8530; TTY: 711; fax: 504-849-6928; email: donna.klein@peopleshealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Donna Klein, Peoples Health general counsel and civil rights coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

PEOPLES HEALTH

www.peopleshealth.com

Peoples Health Member Services

METHOD	Member Services – Contact Information
CALL:	**1-800-222-8600** Calls to this number are free. We are available seven days a week, from 8 a.m. to 8 p.m. If you contact us on a weekend or holiday, you may need to leave a message, but we will return your call within one business day. Member services also has free language interpreter services available for non-English speakers.
TTY:	**1-800-846-5277** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY relay service operates 24 hours a day, seven days a week.
FAX:	**504-849-6906**
WRITE:	**Member Services Department** Peoples Health Three Lakeway Center 3838 N. Causeway Blvd., Ste. 2200 Metairie, LA 70002 phn.member@peopleshealth.com
WEBSITE:	http://www.peopleshealth.com

Senior Health Insurance Information Program (Louisiana SHIP)

Senior Health Insurance Information Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact Information
CALL:	**1-800-259-5300**
WRITE:	Louisiana Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804
WEBSITE:	http://www.ldi.la.gov/SHIIP