ANNUAL NOTICE OF CHANGES FOR 2019

PEOPLES HEALTH
Your **Medicare Health** Team

PEOPLES HEALTH CHOICES GOLD (HMO-POS)

offered by Peoples Health

You are currently enrolled as a member of Peoples Health Choices Gold.
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.

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What to do now

1. ASK: Which changes apply to you

❏ **Check the changes to our benefits and costs to see if they affect you.**

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.1 and 2.5 for information about benefit and cost changes for our plan.

❏ **Check the changes in the booklet to our prescription drug coverage to see if they affect you.**

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

❏ **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 2.3 for information about our *Provider Directory*.

❏ **Think about your overall health care 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 and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

❏ **Think about whether you are happy with our plan.**

2. COMPARE: Learn about other plan choices

❏ **Check coverage and costs of plans in your area.**

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your *Medicare & You* handbook.
- Look in Section 4.2 to learn more about your choices.

❏ **Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.**

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Peoples Health Choices Gold, you don't need to do anything. You will stay in Peoples Health Choices Gold.
- To **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15 and December 7, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Peoples Health Choices Gold.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document may be made available in alternate formats.
- **Coverage under this plan qualifies as qualifying health coverage (QHC)** 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.

About Peoples Health Choices Gold

- 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 Gold.

Summary of Important Costs for 2019

The following table compares the 2018 costs and 2019 costs for Peoples Health Choices Gold 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 *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
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 2.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $10 per visit Specialist visits: $35 per visit	Primary care visits: $0 per visit Specialist visits: $35 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.	$195 per day for days 1-7; $0 per day for days 8 and beyond	$195 per day for days 1-7; $0 per day for days 8 and beyond
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0	Deductible: $0

Cost	2018 (this year)	2019 (next year)
	Copayments/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 for a 30-day supply from a retail pharmacy with preferred cost-sharing and $4 for a 30-day supply from a retail pharmacy with standard cost-sharing • Drug Tier 1: $0 for a 90-day supply from a retail or mail-order pharmacy with preferred cost-sharing and $12 for a 90-day supply from a retail or mail-order pharmacy with standard cost-sharing • Drug Tier 2: $10 for a 30-day supply from a retail pharmacy with preferred cost-sharing and $15 for a 30-day supply from a retail pharmacy with standard cost-sharing • Drug Tier 2: $30 for a 90-day supply from a retail or mail-order pharmacy with preferred cost-sharing and $45 for a 90-day supply from a retail or mail-order pharmacy with standard cost-sharing	Copayments/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 for a 30-day supply from a retail pharmacy • Drug Tier 1: $0 for a 90-day supply from a retail or mail-order pharmacy • Drug Tier 2: $10 for a 30-day supply from a retail pharmacy • Drug Tier 2: $30 for a 90-day supply from a retail pharmacy or $0 for a 90-day supply from a mail-order pharmacy

Cost	2018 (this year)	2019 (next year)
	• Drug Tier 3: $37 for a 30-day supply from a retail pharmacy with preferred cost-sharing and $47 for a 30-day supply from a retail pharmacy with standard cost-sharing • Drug Tier 3: $111 for a 90-day supply from a retail or mail-order pharmacy with preferred cost-sharing and $141 for a 90-day supply from a retail or mail-order pharmacy with standard cost-sharing • Drug Tier 4: $80 for a 30-day supply from a retail pharmacy with preferred cost-sharing and $90 for a 30-day supply from a retail pharmacy with standard cost-sharing • Drug Tier 4: $240 for a 90-day supply from a retail or mail-order pharmacy with preferred cost-sharing and $270 for a 90-day supply from a retail or mail-order pharmacy with standard cost-sharing	• Drug Tier 3: $30 for a 30-day supply from a retail pharmacy • Drug Tier 3: $90 for a 90-day supply from a retail or mail-order pharmacy • Drug Tier 4: $80 for a 30-day supply from a retail pharmacy • Drug Tier 4: $240 for a 90-day supply from a retail or mail-order pharmacy

Cost	2018 (this year)	2019 (next year)
	• Drug Tier 5: 33% coinsurance for a 30-day supply from a retail pharmacy and for a 90-day supply from a retail or mail-order pharmacy	• Drug Tier 5: 33% coinsurance for a 30-day supply from a retail or mail-order pharmacy; a 90-day supply is not covered

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from Peoples Health Choices Gold (HMO) to Peoples Health Choices Gold (HMO-POS).

We will send you a new plan ID card that reflects your new name. This plan name will be used in future communications from us.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Part B premium reduction benefit The plan automatically pays a part of your Medicare Part B premium to Medicare.	Not offered	Your plan pays $10 of your Medicare Part B premium.

- 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 2.2 – 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	2018 (this year)	2019 (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 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 2.3 – Changes to the Provider Network

There are changes to our network of providers 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 2019 *Provider Directory* to see if your providers (primary care physician, specialists, hospitals, etc.) are 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.
- We will make a good faith effort to 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 health care 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 2.4 – 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.

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 2019 *Provider Directory* to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The following information 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 the *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Cardiac rehabilitation services	Up to 36 additional visits for cardiac rehabilitation services beyond what Medicare covers are covered.	Additional visits for cardiac rehabilitation services beyond what Medicare covers are not covered.
Chiropractic services	You pay a $20 copayment for Medicare-covered chiropractic services from a network provider.	You pay a $15 copayment for Medicare-covered chiropractic services from a network provider.
Dental services	You pay a $40 copayment for Medicare-covered comprehensive dental services from a network provider. Prosthodontics (including repairs and adjustments) are not covered.	You pay a $35 copayment for Medicare-covered comprehensive dental services from a network provider. Prosthodontics are covered. You pay a $206 copayment to a $217.75 copayment for dentures and denture frameworks. You pay a $20 copayment for denture

Cost	2018 (this year)	2019 (next year)
		adjustments. You pay a $30 copayment to a $45 copayment for denture repairs and replacement of missing or broken teeth in a denture. One denture is covered every 60 months.
	There is an annual plan coverage maximum of $1,500 for comprehensive services not normally covered by Medicare, as well as preventive services, including X-rays.	There is an annual plan coverage maximum of $2,000 for comprehensive services not normally covered by Medicare, as well as preventive services, including X-rays.
Hearing services	You pay a $40 copayment for each Medicare-covered diagnostic hearing exam from a network provider.	You pay a $0 copayment for each Medicare-covered diagnostic hearing exam from a network provider.
	Routine hearing exams are not covered.	You pay a $40 copayment for one routine hearing exam each year from a network provider.
	Hearing exams for evaluation and fitting of hearing aids are not covered.	You pay a $0 copayment for one hearing exam for evaluation and fitting of hearing aids per year from a network provider.
	Hearing aids are not covered.	You pay a $0 copayment for up to two hearing aids (one for each ear) per year, up to a maximum of $1,000, from a network provider. Limit is for both ears combined.

Cost	2018 (this year)	2019 (next year)
		There is a network of audiologists and hearing instrument specialists that you must use for hearing aids and for hearing exams for evaluation and fitting of hearing aids to be covered.
Help with certain chronic conditions – respite care	Respite care is not covered.	If you have been diagnosed with Alzheimer's disease or dementia, you pay a $0 copayment for each respite care session, up to 12 sessions per year from the network respite care provider. Each session is up to four hours. You must meet plan rules documenting that you have either medical condition. Respite care provides caregivers with a "respite," or temporary break, from their caregiving duties. This benefit requires prior authorization from Peoples Health.
Meals after an inpatient hospital stay	Meals are not covered.	You pay a $0 copayment for up to two prepared meals per day for five days (up to 10 meals total) following a discharge from an inpatient hospital stay, an inpatient rehabilitation stay, or a long-term acute care facility stay to your

Cost	2018 (this year)	2019 (next year)
		home or another household in Louisiana. Meals are not covered following a discharge from an inpatient mental health stay, a skilled nursing facility stay, or an observation stay. Meals are prepared and delivered by the network meal provider. We will work with you at the time of your discharge to set up meals based on your health needs. This benefit requires prior authorization from Peoples Health.
Medicare Part B prescription drugs	You pay 15% of the total cost at a network provider for Medicare Part B-covered drugs other than chemotherapy drugs and Medicare-covered infusion therapy other than home infusion therapy. Part B drugs are not subject to step therapy requirements.	You pay 20% of the total cost at a network provider for Medicare Part B-covered drugs other than chemotherapy drugs and Medicare-covered infusion therapy other than home infusion therapy. Part B drugs may be subject to step therapy requirements.
Out-of-network benefit	The plan does not offer an out-of-network benefit. Out-of-network services are not covered, except in limited circumstances	The plan offers an out-of-network benefit. You pay 30% of the total costs for the following services from an out-of-

Cost	2018 (this year)	2019 (next year)
	(e.g., emergency care and urgently needed care).	network provider: • Inpatient hospital care • Inpatient mental health care • Skilled nursing facility care • Cardiac rehabilitation services • Pulmonary rehabilitation services • Supervised exercise therapy • Partial hospitalization services • Home health agency care • Chiropractic services • Outpatient rehabilitation services • Physician/ practitioner services from a specialist or health care professional other than a primary care physician • Outpatient mental health care • Podiatry services • Outpatient diagnostic tests and therapeutic services and supplies, including lab services, diagnostic radiological

Cost	2018 (this year)	2019 (next year)
		services, therapeutic radiological services, outpatient X-ray services and outpatient blood services • Outpatient hospital services • Outpatient surgery • Outpatient substance abuse services • Ambulance services, including ground and air ambulance • Durable medical equipment • Prosthetic devices and related supplies • Diabetic supplies and diabetes shoes or inserts • Dialysis • Medicare Part B prescription drugs There is a $1,500 deductible for covered out-of-network services. All out-of-network services require prior authorization except for podiatry services, and physician or practitioner services from a physician or a health care professional other than a primary care physician.

Cost	2018 (this year)	2019 (next year)
Outpatient diagnostic tests – diagnostic colonoscopy	For each Medicare-covered diagnostic colonoscopy, you pay a $10 copayment at a network primary care physician office and a $40 copayment at a network specialist office or other network location.	You pay a $0 copayment for a Medicare-covered diagnostic colonoscopy at a network provider.
Outpatient hospital services – observation services	You pay a $0 to $120 copayment or 15% to 30% of the total cost for each Medicare-covered hospital service, depending on the service, during an observation visit at a network outpatient hospital facility.	You pay a $250 copayment for a Medicare-covered observation visit at a network outpatient hospital facility.
Over-the-counter items	Over-the-counter items are not covered.	You pay a $0 copayment for over-the-counter health-related items and nonprescription medications, up to $100 every quarter of the year (Jan. 1–March 31; April 1–June 30; July 1–Sept. 30; and Oct. 1–Dec. 31). Items must be purchased from the network mail-order provider. Categories of covered items include vitamins and minerals, as well as products for allergies, colds, digestive health, eye care, first aid, incontinence, oral care, pain relief, personal care,

Cost	2018 (this year)	2019 (next year)
		and foot care. There are limits on how many of each item you can order. Covered items may change during this year.
Physician/practitioner services	You pay a $10 copayment for each visit to your network primary care physician for Medicare-covered services.	You pay a $0 copayment for each visit to your network primary care physician for Medicare-covered services.
Podiatry services	You pay a $40 copayment for each Medicare-covered visit to a network provider for medically necessary foot care.	You pay a $35 copayment for each Medicare-covered visit to a network provider for medically necessary foot care.
Pulmonary rehabilitation services	You pay a $0 copayment for Medicare-covered pulmonary rehabilitation services.	You pay a $15 copayment for Medicare-covered pulmonary rehabilitation services.
Vision care	You pay a $40 copayment for Medicare-covered exams and services from a network provider to diagnose and treat diseases and conditions of the eye. You pay a $40 copayment for one supplemental routine eye exam per year from a network provider.	You pay a $35 copayment for Medicare-covered exams and services from a network provider to diagnose and treat diseases and conditions of the eye. You pay a $35 copayment for one supplemental routine eye exam per year from a network provider.

Section 2.6 – 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 provided electronically.

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 the *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 temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 30 days of medication rather than the amount provided in 2018 (98-day supply of medication). (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 2018, you usually submit a new formulary exception request for that drug for 2019 if you need to continue taking it.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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 receive "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 8.1 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 the *Evidence of Coverage* for more information about the stages.)

The following information 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 *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (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 the *Evidence of Coverage*.

Stage	2018 (this year)	2019 (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 the *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 $4 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 drug tier):** *Standard cost-sharing:* You pay $90 per prescription. *Preferred cost-sharing:* You pay $80 per prescription. **Tier 5 (specialty tier):** *Standard cost-sharing:* You pay 33% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 (preferred generic tier):** You pay $0 per prescription. **Tier 2 (generic tier):** You pay $10 per prescription. **Tier 3 (preferred brand tier):** You pay $30 per prescription. **Tier 4 (nonpreferred drug tier):** You pay $80 per prescription. **Tier 5 (specialty tier):** You pay 33% of the total cost.

Stage	2018 (this year)	2019 (next year)
	Preferred cost-sharing: You pay 33% of the total cost. ______________ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	____________ Once your total drug costs have reached $3,820, 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 the *Evidence of Coverage*.

SECTION 3 Administrative Changes

	2018 (this year)	2019 (next year)
Service area	Your service area includes these parishes in Louisiana: Acadia, Calcasieu, Cameron, Evangeline, Iberia, Lafayette, St. Bernard, St. Landry, St. Martin and Vermilion.	Your service area includes these parishes in Louisiana: Acadia, Bossier, Caddo, Calcasieu, Cameron, Evangeline, Iberia, Lafayette, Ouachita, St. Bernard, St. Landry, St. Martin and Vermilion.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Peoples Health Choices Gold

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 2019.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 Gold.
- 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 Gold.
- 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 8.1 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 5 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, 2019.

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 may be 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.*

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 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 7 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 8 Questions?

Section 8.1 – 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, we will reach out to you within one business day. Calls to these numbers are free.

Read the 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Peoples Health Choices Gold. 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. You can find the *Evidence of Coverage* on our website at http://www.peopleshealth.com, or you can request a hard copy. Call us at the phone number printed on the special notice included with this *Annual Notice of Changes*.

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 8.2 – 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 2019*

You can read the *Medicare & You 2019* 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.

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).

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

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）。

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).

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).

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).

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-222-8600 (رقم هاتف الصم والبكم: 1-800-846-5277).

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

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。

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-222-8600 (TTY: 1-800-846-5277).

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

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).

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). Peoples Health also 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 the member services department. 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 our civil rights coordinator; Peoples Health, Three Lakeway Center, 3838 N. Causeway Blvd., Suite 2200, Metairie, LA 70002; 504-849-4685, 225-346-5704 or toll-free 1-800-222-8600; TTY: 711; fax: 504-849-6959; email: civilrightscoordinator@peopleshealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Peoples Health Member Services

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, we will reach out to you 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.

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

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