2019 SUMMARY OF BENEFITS

Peoples Health Choices Gold (HMO-POS)

January 1, 2019 – December 31, 2019

To join Peoples Health Choices Gold, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in one of these Louisiana parishes: Acadia, Bossier, Caddo, Calcasieu, Cameron, Evangeline, Iberia, Lafayette, Ouachita, St. Bernard, St. Landry, St. Martin and Vermilion.

The benefit information provided is a summary of the medical services we cover and what you pay. This information is not a complete description of benefits. Call at 1-855-890-5987 for more information. For a complete list of covered services, call us or see the *Evidence of Coverage* on our website. This document may be available in alternate formats.

We have a network of doctors, hospitals, pharmacies and other providers available to you. Your plan also covers you for some services from providers outside of our network. In most cases, you will pay a higher cost for the service if you see an out-of-network provider.

We cover Part D drugs, as well as Part B drugs such as chemotherapy and other drugs administered by a hospital or provider.

You can search our formulary (list of covered Part D prescription drugs) and our *Provider Directory* at http://www.peopleshealth.com/searchtools.

For more information, call us toll-free at **1-855-890-5987**. TTY users should call **1-800-846-5277**. We're 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. Or visit us at http://www.peopleshealth.com.

If you want to know more about Original Medicare coverage and costs, look in your current Medicare & You handbook. View it online at https://www.medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Peoples Health is a Medicare Advantage organization with a Medicare contract to offer HMO plans. Enrollment depends on annual Medicare contract renewal.

Premium, Deductible and Maximum Out-of-Pocket Amount	What You Pay
Monthly Plan Premium	$0
Part B Premium Buy-Down	Your plan automatically pays a part of your Medicare Part B premium to Medicare. Your plan pays $10 of your premium.
Deductible	$1,500 out-of-network deductible for covered services received from an out-of-network provider $50 deductible for comprehensive dental services not normally covered by Medicare and received from a network provider
Maximum Out-of-Pocket Responsibility	$6,700 This amount is the most you pay annually for copays, coinsurance and other costs for Medicare Part A and Part B medical services received from a network provider. It does not include what you pay for prescription drugs. There is no maximum out-of-pocket responsibility for services received from out-of-network providers.

Medical Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Inpatient Hospital Coverage	$195 each day for days 1–7 $0 each day for days 8 and beyond	30% coinsurance for each inpatient stay
	Services require prior authorization, except in an emergency.	
Outpatient Hospital Coverage	$250 for each visit for outpatient hospital services Some services may require prior authorization.	30% coinsurance for outpatient hospital services Some services may require prior authorization.

Medical Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Doctor Visits • Primary care physician visit • Specialist physician visit	$0 $35 Some specialist services, such as surgical services, may require prior authorization.	Not covered. 30% coinsurance Some specialist services, such as surgical services, may require prior authorization.
Preventive Care	$0 Any additional preventive services Medicare approves during the plan year will be covered. Some services may require prior authorization.	Not covered.
Emergency Care	$80 If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Emergency care coverage is provided worldwide. You are covered for emergency and urgently needed care outside of the United States and its territories up to an annual combined maximum of $5,000.	
Urgently Needed Services	$40 Urgently needed care coverage is provided worldwide. You are covered for emergency and urgently needed care outside of the United States and its territories up to an annual combined maximum of $5,000.	
Diagnostic Services, Labs and Imaging • Diagnostic tests, procedures and radiology	**For echocardiography and diagnostic procedures, tests and radiology:** • $10 at a primary care physician office • $40 at a specialist office or other location **For diagnostic colonoscopy:** $0	30% coinsurance for echocardiography, advanced imaging, nuclear medicine, diagnostic colonoscopy, and diagnostic radiology procedures, tests and services

Medical Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Diagnostic Services, Labs and Imaging *continued*	**For X-rays:** • $10 at a physician office • $30 at an outpatient facility	30% coinsurance for X-rays
• Lab services	**For lab services:** • $0 at a lab provider or an outpatient hospital contracted to provide lab services to Peoples Health plan members • $10 at a primary care physician office • $40 at a specialist office • 30% coinsurance at an outpatient hospital not contracted to provide lab services to Peoples Health plan members	30% coinsurance for lab services
• Advanced imaging *(e.g., MRI)*	**For advanced imaging and nuclear medicine:** $120 You also pay the office visit copay for services received at a physician office. Some services may require prior authorization.	30% coinsurance for advanced imaging and nuclear medicine Some services may require prior authorization.
Hearing Services • Hearing exams	• $0 for a diagnostic hearing exam • $40 for one routine hearing exam each year	Not covered.
• Hearing aids	• $0 for up to two hearing aids (one per ear) per year, up to a maximum of $1,000 for both ears combined • $0 for one hearing exam for evaluation and fitting of hearing aids per year	

Medical Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Dental Services • Preventive oral exam • Preventive prophylaxis (cleaning) • X-rays • Comprehensive dental services	$0, one every six months $0, one every six months $0, one every 12 months $35 for comprehensive dental services normally covered by Medicare; other comprehensive services are also covered, and there is a $50 deductible for these services Some services may require prior authorization.	Not covered.
Vision Services • Exams and services to diagnose and treat diseases and conditions of the eye • Supplemental routine eye exams	$35 Some services, such as surgical services, may require prior authorization.	Not covered.
Mental Health Services • Inpatient care • Outpatient individual or group therapy • Outpatient substance abuse services	$195 each day for days 1–7 $0 each day for days 8–90 • $40 for each visit • $40 for each specialist visit • $50 for each outpatient hospital visit Services require prior authorization and must be arranged by a network behavioral health provider.	30% coinsurance for each inpatient stay 30% coinsurance for each visit 30% coinsurance for each visit Services require prior authorization.

Medical Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Skilled Nursing Facility	$0 each day for days 1–20 $160 each day for days 21–100 You are covered for up to 100 days each benefit period. Services require prior authorization.	30% coinsurance for each stay for up to 100 days each benefit period. Services require prior authorization.
Physical Therapy	$15 Services require prior authorization.	30% coinsurance Services require prior authorization.
Ambulance	$235 for each one-way ground or air service Nonemergency services require prior authorization.	30% coinsurance for each one-way ground or air service Nonemergency services require prior authorization.
Transportation	Not covered.	Not covered.
Medicare Part B Drugs	$0 for home infusion therapy 20% coinsurance for Part B-covered chemotherapy drugs, other Part B-covered drugs and other infusion therapy Some services may require prior authorization.	30% coinsurance Some services may require prior authorization.

Part D Prescription Drugs	What You Pay			
Phase 1: Initial Coverage Stage	**In-network retail costs for a 30-day supply**	**In-network retail costs for a 90-day supply**	**In-network mail-order costs for a supply**	**Out-of-network costs for a 30-day supply**
Tier 1: (includes preferred generics)	$0	$0	$0 (90-day)	$0
Tier 2: (includes generics)	$10	$30	$0 (90-day)	$10
Tier 3: (includes preferred brands and generics)	$30	$90	$90 (90-day)	$30
Tier 4: (includes nonpreferred brands and generics)	$80	$240	$240 (90-day)	$80
Tier 5: (includes specialty brands and generics)	33% coinsurance	Not covered	33% coinsurance (30-day)	33% coinsurance
Cost-sharing varies depending on which phase of the Part D prescription drug coverage cycle you are in. It also varies depending on the pharmacy's status (retail or mail-order pharmacy, long-term care pharmacy or home infusion pharmacy) and on whether you get a 30-day supply or a 90-day supply. For more information, call us or see the plan's *Evidence of Coverage* on our website.				

Additional Benefits	What You Pay for Plan-Covered Services From an In-Network Provider	What You Pay for Plan-Covered Services From an Out-of-Network Provider
Meals After an Inpatient Hospital Stay	$0 You are covered 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 home or another household in Louisiana. Services require prior authorization.	Not covered.
Over-the-Counter Items	$0 You are covered 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.	Not covered.
Respite Care	$0 If you have Alzheimer's disease or dementia, you are covered for respite care sessions, up to 12 sessions per year. Each session is up to four hours. Services require prior authorization.	Not covered.

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 1-800-222-0068 (رقم هاتف الصم والبكم: 1-800-648-7725.

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, ການບໍລິການຊ່ວຍ ເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. 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 .(TTY: 1-800-846-5277) 1-800-222-8600

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.

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative toll-free at **1-855-890-5987**. TTY users should call **1-800-846-5277**. We're 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.

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit http://www.peopleshealth.com or call 1-855-890-5987 to view a copy of the EOC.

- ☐ Review the *Provider Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- ☐ Review the *Provider Directory* to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. Your plan automatically pays $10 of your Medicare Part B premium to Medicare.

- ☐ Benefits, premiums, copayments or coinsurance may change on January 1, 2020.

- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.