2020
ANNUAL NOTICE OF CHANGES

Important changes to your plan

Peoples Health Choices Gold (HMO-POS)

Toll-free **1-800-222-8600**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.peopleshealth.com

Do we have the right address for you?
Please let us know so we can keep you informed about your plan.

PEOPLES HEALTH
*Your **Medicare Health** Team*

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Peoples Health Choices Gold (HMO-POS) offered by Peoples Health

Annual Notice of Changes for 2020

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.

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 1.1 and 1.5 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 **2020 Drug List** and look in Section 1.6 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.

OMB Approval 0938-1051
(Expires: December 31, 2021)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, 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 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 2.2 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, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Peoples Health Choices Gold.
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- This document is 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 2020

The table below compares the 2019 costs and 2020 costs for Peoples Health Choices Gold in several important areas. **Please note this is only a summary of changes.** A copy of the **Evidence of Coverage** is located on our website at http://www.peopleshealth.com. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$1,500 for out-of-network services	$1,500 for out-of-network services
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: $0 per visit Specialist visits: $35 per visit	Primary care visits: $0 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.	$195 per day for days 1–7; $0 per day for days 8 and beyond	$195 per day for days 1–10; $0 per day for days 11 and beyond

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment or Coinsurance during the Initial Coverage Stage: • Drug Tier 1, retail pharmacy: $0 for a 30-day supply • Drug Tier 1, retail pharmacy: $0 for a 90-day supply • Drug Tier 1, standard mail-order pharmacy: $0 for a 90-day supply • Drug Tier 1, preferred mail-order pharmacy: not applicable • Drug Tier 1, out-of-network pharmacy: $0 for a 30-day supply • Drug Tier 1, long-term care pharmacy: $0 for a 31-day supply • Drug Tier 2, retail pharmacy: $10 for a 30-day supply • Drug Tier 2, retail pharmacy: $30 for a 90-day supply • Drug Tier 2, standard mail-order pharmacy: $0 for a 90-day supply • Drug Tier 2, preferred mail-order pharmacy: not applicable	Deductible: $0 Copayment or Coinsurance during the Initial Coverage Stage: • Drug Tier 1, retail pharmacy: $0 for a 30-day supply • Drug Tier 1, retail pharmacy: $0 for a 90-day supply • Drug Tier 1, standard mail-order pharmacy: $0 for a 90-day supply • Drug Tier 1, preferred mail-order pharmacy: $0 for a 90-day supply • Drug Tier 1, out-of-network pharmacy: $0 for a 30-day supply • Drug Tier 1, long-term care pharmacy: $0 for a 31-day supply • Drug Tier 2, retail pharmacy: $10 for a 30-day supply • Drug Tier 2, retail pharmacy: $30 for a 90-day supply • Drug Tier 2, standard mail-order pharmacy: $30 for a 90-day supply • Drug Tier 2, preferred mail-order pharmacy: $0 for a 90-day supply

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (continued) (See Section 1.6 for details.)	• Drug Tier 2, out-of-network pharmacy: $10 for a 30-day supply • Drug Tier 2, long-term care pharmacy: $10 for a 31-day supply • Drug Tier 3, retail pharmacy: $30 for a 30-day supply • Drug Tier 3, retail pharmacy: $90 for a 90-day supply • Drug Tier 3, standard mail-order pharmacy: $90 for a 90-day supply • Drug Tier 3, preferred mail-order pharmacy: not applicable • Drug Tier 3, out-of-network pharmacy: $30 for a 30-day supply • Drug Tier 3, long-term care pharmacy: $30 for a 31-day supply • Drug Tier 4, retail pharmacy: $80 for a 30-day supply • Drug Tier 4, retail pharmacy: $240 for a 90-day supply • Drug Tier 4, standard mail-order pharmacy: $240 for a 90-day supply	• Drug Tier 2, out-of-network pharmacy: $10 for a 30-day supply • Drug Tier 2, long-term care pharmacy: $10 for a 31-day supply • Drug Tier 3, retail pharmacy: $45 for a 30-day supply • Drug Tier 3, retail pharmacy: $135 for a 90-day supply • Drug Tier 3, standard mail-order pharmacy: $135 for a 90-day supply • Drug Tier 3, preferred mail-order pharmacy: $135 for a 90-day supply • Drug Tier 3, out-of-network pharmacy: $45 for a 30-day supply • Drug Tier 3, long-term care pharmacy: $45 for a 31-day supply • Drug Tier 4, retail pharmacy: $100 for a 30-day supply • Drug Tier 4, retail pharmacy: $300 for a 90-day supply • Drug Tier 4, standard mail-order pharmacy: $300 for a 90-day supply

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (continued) (See Section 1.6 for details.)	• Drug Tier 4, preferred mail order pharmacy: not applicable • Drug Tier 4, out-of-network pharmacy: $80 for a 30-day supply • Drug Tier 4, long-term care pharmacy: $80 for a 31-day supply • Drug Tier 5: 33% coinsurance for a 30-day supply from a retail or standard mail-order pharmacy; a 90-day supply is not covered • Drug Tier 5, preferred mail-order pharmacy: not applicable • Drug Tier 5, out-of-network pharmacy: 33% coinsurance for a 30-day supply • Drug Tier 5, long-term-care pharmacy: 33% coinsurance for a 31-day supply	• Drug tier 4, preferred mail-order pharmacy: $300 for a 90-day supply • Drug Tier 4, out-of-network pharmacy: $100 for a 30-day supply • Drug Tier 4, long-term care pharmacy: $100 for a 31-day supply • Drug Tier 5, retail pharmacy: 33% coinsurance for a 30-day supply or a 90-day supply • Drug Tier 5, standard or preferred mail-order pharmacy: 33% coinsurance for a 90-day supply • Drug Tier 5, out-of-network pharmacy: 33% coinsurance for a 30-day supply • Drug Tier 5, long-term-care pharmacy: 33% coinsurance for a 31-day supply

Annual Notice of Changes for 2020

Table of Contents

SECTION 1: Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2019 (this year)	2020 (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.	Your plan pays $10 of your Medicare Part B premium.	Not offered

- 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	2019 (this year)	2020 (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 1.3 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 2020 Provider Directory to see if your providers (primary care provider, 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, we must 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 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.

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 2020 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 **2020 Evidence of Coverage**.

Cost	2019 (this year)	2020 (next year)
Ambulance services	You pay a $235 copayment for Medicare-covered ambulance services.	You pay a $260 copayment for Medicare-covered ambulance services.
Annual routine physical exam	Annual routine physical exam is **not** covered (in-network).	You pay a $0 copayment (in-network).
Cardiac rehabilitation and intense cardiac rehabilitation	You pay a $15 copayment for Medicare-covered cardiac rehabilitation services from a network provider.	You pay a $20 copayment for Medicare-covered cardiac rehabilitation services from a network provider.
Chiropractic services	You pay a $15 copayment for Medicare-covered chiropractic services from a network provider.	You pay a $20 copayment for Medicare-covered chiropractic services from a network provider.

Cost	2019 (this year)	2020 (next year)
Dental services	You pay a $67 copayment for extractions from a network provider. 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.	You pay a $15 copayment for extractions from a network provider. There is an annual plan coverage maximum of $1,250 for comprehensive services not normally covered by Medicare, as well as preventive services, including X-rays.
Emergency services	You pay an $80 copayment within the U.S. and its territories. You pay an $80 copayment for worldwide services.	You pay a $90 copayment within the U.S. and its territories. You pay a $90 copayment for worldwide services.
Health and wellness products (over-the-counter items)	$100 credit quarterly. Your credit amount expires at the end of the quarter. Nicotine replacement therapy items are **not** covered.	$40 credit quarterly. Place your order online through Walmart at www.HealthyBenefitsPlus.com/HWP, over the phone, or send an order form by mail. Credit amounts expire at the end of the quarter. Nicotine replacement therapy items are covered.
Hearing services	You pay a $0 copayment for each Medicare-covered diagnostic hearing exam from a network provider. You pay a $40 copayment for one routine hearing exam per year from a network provider.	You pay a $20 copayment for each Medicare-covered diagnostic hearing exam from a network provider. You pay a $20 copayment for one routine hearing exam per year from a network provider.

Cost	2019 (this year)	2020 (next year)
Inpatient hospital services	You pay a $195 copayment each day for days 1–7 and $0 copayment for days 8 and beyond 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 $1,365 for each inpatient admission	You pay a $195 copayment each day for days 1–10 and $0 copayment for days 11 and beyond 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 $1,950 for each inpatient admission.
Inpatient mental health care	You pay a $195 copayment each day for days 1–7 and a $0 copayment for days 8–90 for each inpatient admission to a network hospital or network psychiatric facility for Medicare-covered services. Out-of-pocket costs are limited to $1,365 for each inpatient admission.	You pay a $195 copayment each day for days 1–9 and a $0 copayment for days 10–90 for each inpatient admission to a network hospital or network psychiatric facility for Medicare-covered services. Out-of-pocket costs are limited to $1,755 for each inpatient admission.

Cost	2019 (this year)	2020 (next year)
Medicare Part B prescription drugs	Part B drugs may be subject to step therapy requirements. You pay 0% of the total cost for Medicare-covered home infusion therapy from a home infusion network provider and 20% of the total cost for all other Medicare-covered infusion therapy from a network provider.	Part B drugs are **not** subject to step therapy requirements. You pay 20% of the total cost for all Medicare-covered infusion services, including home infusion, from a network provider.
Opioid treatment program services	**Not** Covered	You pay a $0 copayment at a network provider — See your **Evidence of Coverage** to learn more.
Outpatient diagnostic tests and therapeutic radiology services	You pay a $10 copayment at a network PCP's office and a $40 copayment at a network specialist's office for Medicare-covered diagnostic procedures and tests. You pay a $120 copayment for Medicare-covered diagnostic mammography from a network provider.	You pay a $10 copayment at a contracted radiology facility and a $40 copayment at a network physician's office (PCP or specialist) for Medicare-covered diagnostic procedures and tests. You pay a $0 copayment for Medicare-covered diagnostic mammography from a network provider.
Outpatient surgery	You pay a $200 copayment at a network ambulatory surgical center and a $250 copayment at a network outpatient hospital facility for each Medicare-covered visit for outpatient surgery, other than for diagnostic colonoscopies.	You pay a $250 copayment at network ambulatory surgical center or a network outpatient hospital facility for each Medicare-covered visit for outpatient surgery, other than for diagnostic colonoscopies.

Cost	2019 (this year)	2020 (next year)
Podiatry services	You pay a $35 copayment for each Medicare-covered visit to a network provider for medically necessary foot care.	You pay a $40 copayment for each Medicare-covered visit to a network provider for medically necessary foot care.
Pulmonary rehabilitation services	You pay a $15 copayment for Medicare-covered pulmonary rehabilitation services from a network provider.	You pay a $20 copayment for Medicare-covered pulmonary rehabilitation services from a network provider.
Rehabilitation services	You pay a $15 copayment for Medicare-covered services from a network provider.	You pay a $20 copayment for Medicare-covered services from a network provider.
Services by Specialists and other health care professionals	You pay a $35 copayment for Medicare-covered services from a network provider.	You pay a $40 copayment for Medicare-covered services from a network provider.
Skilled nursing facility (SNF) services	You pay a $0 copayment each day for days 1-20 and a $160 copayment each day for days 21-100 for each Medicare-covered skilled facility stay at a network provider.	You pay a $0 copayment each day for days 1-20 and a $165 copayment each day for days 21-100 for each Medicare-covered skilled facility stay at a network provider.
Supervised exercise therapy	You pay a $15 copayment for Medicare-covered exercise therapy from a network provider.	You pay a $20 copayment for Medicare-covered exercise therapy from a network provider.

Cost	2019 (this year)	2020 (next year)
Virtual medical visits	**Not** Covered	You pay a $0 copayment. Virtual medical visits are available 24 hours a day, 7 days a week. Visit www.amwell.com to access virtual medical visits.

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 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 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 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.

Starting in 2020, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

If you have obtained approval for a formulary exception this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. If your approval expires on December 31, 2019, you may need to obtain a new approval in order to continue to receive your drug in 2020, if the drug is still non-formulary and you and your doctor feel it is needed. Any exception you received in 2019 is not guaranteed for 2020.

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.

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 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 6.1 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 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**, which is located on our website at http://www.peopleshealth.com. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.)

Changes to the Deductible Stage

	2019 (this year)	**2020 (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**.

Cost	2019 (this year)	2020 (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 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 (non-preferred drug tier):** You pay $80 per prescription. **Tier 5 (specialty tier):** 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 $45 per prescription. **Tier 4 (non-preferred drug tier):** You pay $100 per prescription. **Tier 5 (specialty tier):** You pay 33% of the total cost.
	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,020, 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: Deciding Which Plan to Choose

Section 2.1 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 2020.

Section 2.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read **Medicare & You 2020**, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://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 6.1 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 3: 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, 2020.

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**.

If you enrolled in a Medicare Advantage plan for January 1, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the **Evidence of Coverage**.

SECTION 4: 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 5: 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 4:30 p.m.

SECTION 6: Questions?

Section 6.1 Getting Help from Peoples Health

Questions? We're here to help. Please call Member Services at 1-800-222-8600. (TTY only, call 711). 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 your 2020 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 2020. For details, look in the **2020 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. A copy of the **Evidence of Coverage** is located on our website at http://www.peopleshealth.com. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

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 6.2 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 (https://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 https://www.medicare.gov and click on "Find health & drug plans").

Read Medicare & You 2020

You can read the **Medicare & You 2020** 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 (https://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.

ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-222-8600 (TTY: 711).

請注意：如果您說中文，我們免費為您提供語言協助服務。請致電 1-800-222-8600 (TTY：711)。

PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-800-222-8600 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-222-8600 (ATS 711).

XIN LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Hãy gọi 1-800-222-8600 (TTY: 711).

ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie bitte unter 1-800-222-8600 (TTY: 711) an.

알림: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-222-8600 (TTY: 711)번으로 전화하십시오.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским. Звоните по телефону 1-800-222-8600 (TTY: 711).

تنبيه: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل على الرقم 1-800-222-8600 (TTY: 711).

ATENÇÃO: Se você fala português, contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-222-8600 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。1-800-222-8600（TTY: 711）まで、お電話にてご連絡ください。

โปรดทราบ: หากคุณพูดภาษาไทย **มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โทรศัพท์ถึงหมายเลข** 1-800-222-8600 **(สำหรับผู้มีความบกพร่องทางการฟัง:** 711**)**

ສິ່ງສຳຄັນ:
ຖ້າທ່ານເວົ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາ ບໍ່ເສຍຄ່າ ໃຫ້ທ່ານ. ໃຫ້ໂທຫາ ເບີ 1-800-222-8600 (TTY: 711).

توجه: اگر زبان شما فارسی است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. با شماره 1-800-222-8600 (TTY: 711) تماس بگیرید.

توجہ فرمائیں: اگر آپ اردو زبان بولتے ہیں تو، آپ کے لئے بلامعاوضہ، زبان معاون خدمات، دستیاب ہیں۔ کال کریں 1-800-222-8600 (TTY: 711)۔

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 Choices Gold (HMO-POS)
Member Services:

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. local time.

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 **711**
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.

Peoples Health
Member Services Department
Three Lakeway Center
3838 N. Causeway Blvd., Ste. 2200
Metairie, LA 70002

phn.member@peopleshealth.com

Website **http://www.peopleshealth.com**