Summary of Benefits 2020

Overview of your plan

Peoples Health Choices Gold (HMO-POS)

H1961-017-000

Look inside to take advantage of the health services and drug coverages the plan provides. Call Member Services or go online for more information about the plan.

Toll-free **1-800-978-6598**, TTY **711**
October 1 - December 7: 8 a.m. to 8 p.m. local time, 7 days a week; December 8 - September 30: 8 a.m. to 8 p.m. local time, Monday - Friday

www.peopleshealth.com

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

Y0066_SB_H1961_017_000_2020_M

Summary of Benefits

January 1st, 2020 - December 31st, 2020

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.peopleshealth.com or you can call Member Services for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

Peoples Health Choices Gold (HMO-POS) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

Our service area includes these parishes in:

Louisiana: Acadia, Bossier, Caddo, Calcasieu, Cameron, Evangeline, Iberia, Lafayette, Ouachita, St. Landry, St. Martin, Vermilion.

Use network providers and pharmacies.

Peoples Health Choices Gold (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to www.peopleshealth.com to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

Peoples Health Choices Gold (HMO-POS)

Premiums and Benefits	In-Network	Out-of-Network
Monthly Plan Premium	There is no monthly premium for this plan.	
Annual Medical Deductible	No deductible	$1,500 annually for covered services you receive from out-of-network providers.
	The deductible applies only to the following Medicare-covered benefit categories: Inpatient Hospital Outpatient Hospital - Ambulatory Surgical Center (ASC) Outpatient Hospital - Outpatient Hospital, including surgery Outpatient Hospital Observation Services Doctor Visits - Specialist Diagnostic Tests, Lab and Radiology Services, and X-Rays – Diagnostic radiology services (e.g. MRI) Diagnostic Tests, Lab and Radiology Services, and X-Rays - Lab services Diagnostic Tests, Lab and Radiology Services, and X-Rays - Diagnostic tests and procedures Diagnostic Tests, Lab and Radiology Services, and X-Rays – Therapeutic Radiology Diagnostic Tests, Lab and Radiology Services, and X-Rays - Outpatient X-rays Mental Health - Inpatient Visit Mental Health - Outpatient group therapy visit Mental Health - Outpatient individual therapy visit Skilled Nursing Facility (SNF) Physical therapy and speech and language therapy visit Ambulance for ground Ambulance for air Medicare Part B Drugs - Chemotherapy drugs Medicare Part B Drugs - Other Part B drugs Chiropractic Care - Manual manipulation of the spine to correct subluxation Diabetes Management - Diabetes monitoring supplies Diabetes Management - Therapeutic shoes or inserts Durable Medical Equipment (DME) and Related Supplies - Durable Medical Equipment (e.g. wheelchairs, oxygen)	

Premiums and Benefits	In-Network	Out-of-Network
	Durable Medical Equipment (DME) and Related Supplies - Prosthetics (e.g., braces, artificial limbs) Foot Care (podiatry services) - Foot exams and treatment Home Health Care Occupational Therapy Visit Outpatient Substance Abuse - Outpatient group therapy visit Outpatient Substance Abuse - Outpatient individual therapy visit Renal Dialysis	
Maximum Out-of-Pocket Amount (does not include prescription drugs)	$6,700 annually for Medicare-covered services you receive from in-network providers.	Unlimited Out-of-Network
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost for your Part D prescription drugs.	

Peoples Health Choices Gold (HMO-POS)

Benefits		In-Network	Out-of-Network
Inpatient Hospital[2]		$195 copay per day: for days 1-10 $0 copay per day: for days 11 and beyond	30% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Cost sharing for additional plan covered services will apply.	Ambulatory Surgical Center (ASC)[2]	$0 copay for a diagnostic colonoscopy $250 copay otherwise	30% coinsurance
	Outpatient Hospital, including surgery[2]	$0 copay for a diagnostic colonoscopy $250 copay otherwise	30% coinsurance
	Outpatient Hospital Observation Services[2]	$250 copay	30% coinsurance
Doctor Visits	Primary	$0 copay	Not covered
	Specialists[2]	$40 copay	30% coinsurance
	Virtual Medical Visits	Speak to network telehealth providers using your computer or mobile device. Find participating doctors online at www.amwell.com	Not covered
Preventive Care	Medicare-covered	$0 copay	Flu shots: $0 copay All other services: Not covered
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening	

Benefits		In-Network	Out-of-Network
		Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings and monitoring Hepatitis C screening HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including flu shots, hepatitis B shots, pneumococcal shots "Welcome to Medicare" preventive visit (one-time)	
		Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.	
	Routine physical[2]	$0 copay; 1 per year	Not covered
Emergency Care		$90 copay (worldwide) per visit If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the "Inpatient Hospital Care" section of this booklet for other costs. 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 copay 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.	

Benefits		In-Network	Out-of-Network
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)[2]	$0 copay for each diagnostic mammogram $120 copay per service otherwise	30% coinsurance
	Lab services[2]	$0 copay at a lab provider or an outpatient hospital contracted to provide lab services $10 copay at a primary care physician office $40 copay at a specialist office 30% coinsurance at any outpatient hospital facility not contracted to provide lab services	30% coinsurance
	Diagnostic tests and procedures[2]	$10 copay at a contracted radiology facility $40 copay at a physician office	30% coinsurance
	Therapeutic Radiology[2]	$45 copay per service	30% coinsurance
	Outpatient X-rays[2]	$10 copay at a physician office $30 copay at an outpatient hospital facility	30% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues	$20 copay	Not covered
	Routine hearing exam	$20 copay; 1 per year	Not covered
	Hearing aid	$1,000 allowance every year	Not covered

Benefits		In-Network	Out-of-Network
Routine Dental Services	Preventive	$0 copay for covered preventive services	Not covered
	Comprehensive	$50 deductible applies before coverage begins $0 - $217.75 copay for comprehensive dental services	Not covered
	Benefit limit	$1,250 limit on all covered dental services	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	$35 copay	Not covered
	Eyewear after cataract surgery	$0 copay	Not covered
	Routine eye exam	$35 copay; 1 every year	Not covered
	Eyewear	$0 copay every year for a pair of lenses and frames or contact lenses	Not covered
Mental Health	Inpatient visit[2]	$195 copay per day: for days 1-9 $0 copay per day: for days 10-90	30% coinsurance per stay
		Our plan covers 90 days for an inpatient hospital stay.	
	Outpatient group therapy visit[2]	$40 copay	30% coinsurance
	Outpatient individual therapy visit[2]	$40 copay	30% coinsurance
Skilled Nursing Facility (SNF)[2]		$0 copay per day: for days 1-20 $165 copay per day: for days 21-100	30% coinsurance per stay, up to 100 days
		Our plan covers up to 100 days in a SNF.	
Physical therapy and speech and language therapy visit[2]		$20 copay	30% coinsurance

Benefits		In-Network	Out-of-Network
Ambulance[2] Your provider must obtain prior authorization for non-emergency transportation.		\$260 copay for ground \$260 copay for air	30% coinsurance for ground 30% coinsurance for air
Routine Transportation		Not covered	
Medicare Part B Drugs	Chemotherapy drugs[2]	20% coinsurance	30% coinsurance
	Other Part B drugs[2]	20% coinsurance	30% coinsurance

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

<table>
<tr><td>Stage 1: Annual Prescription Deductible</td><td colspan="4">Since you have no deductible for Part D drugs, this payment stage doesn’t apply.</td></tr>
<tr><td rowspan="3">Stage 2: Initial Coverage (After you pay your deductible, if applicable)</td><td colspan="2">Retail</td><td colspan="2">Mail Order</td></tr>
<tr><td colspan="2">Standard</td><td>Preferred</td><td>Standard</td></tr>
<tr><td>30-day supply</td><td>90 day supply</td><td>90-day supply</td><td>90-day supply</td></tr>
<tr><td>Tier 1:
Preferred Generic Drugs</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2:
Generic Drugs</td><td>$10 copay</td><td>$30 copay</td><td>$0 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3:
Preferred Brand Drugs</td><td>$45 copay</td><td>$135 copay</td><td>$135 copay</td><td>$135 copay</td></tr>
<tr><td>Tier 4:
Non-Preferred Drugs</td><td>$100 copay</td><td>$300 copay</td><td>$300 copay</td><td>$300 copay</td></tr>
<tr><td>Tier 5:
Specialty Tier Drugs</td><td>33% coinsurance</td><td>33% coinsurance</td><td>33% coinsurance</td><td>33% coinsurance</td></tr>
<tr><td>Stage 3: Coverage Gap Stage</td><td colspan="4">Tier 1 and Tier 2 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $4,020, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap.</td></tr>
<tr><td>Stage 4: Catastrophic Coverage</td><td colspan="4">After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of:

• 5% coinsurance, or
• $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copay for all other drugs.</td></tr>
</table>

Additional Benefits		In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation[2]	$20 copay	30% coinsurance
Diabetes Management	Diabetes monitoring supplies[2]	$0 copay for each Medicare-covered blood glucose diabetes monitoring supply from a preferred DME provider. 20% coinsurance for each Medicare-covered blood glucose diabetes monitoring supply from other DME providers. Diabetes monitoring supplies must be purchased from a network durable medical equipment provider.	30% coinsurance
	Diabetes Self-management training[2]	$0 copay	Not covered
	Therapeutic shoes or inserts[2]	$10 copay	30% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[2]	20% coinsurance	30% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[2]	20% coinsurance	30% coinsurance
Health Education[2]		$0 copay; Learn how to help manage chronic illness over the phone with telephonic help from clinical staff	Not covered
Fitness program[2]		$0 copay to a network fitness center	Not covered

Additional Benefits		In-Network	Out-of-Network
Foot Care (podiatry services)	Foot exams and treatment[2]	$40 copay	30% coinsurance
Meal Benefit[2]		$0 copay; Coverage for at home meal benefit. Restrictions apply.	Not covered
Home Health Care[2]		$0 copay	30% coinsurance
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.	
Occupational Therapy Visit[2]		$20 copay	30% coinsurance
Opioid Treatment Services		$0 copay	Not covered
Outpatient Substance Abuse	Outpatient group therapy visit[2]	$40 copay in a specialist's office $50 copay in an outpatient hospital	30% coinsurance
	Outpatient individual therapy visit[2]	$40 copay in a specialist's office $50 copay in an outpatient hospital	30% coinsurance
Health & Wellness Products Catalog		$40 credit per quarter to use on approved health products. Order online at Walmart.com, over the phone, or by mail.	
Telemonitoring Services[2]		Specialized home monitoring for members with certain classes of heart failure or who have had a hospital admission for heart failure.	Not covered
Renal Dialysis[2]		20% coinsurance	30% coinsurance

Additional Benefits	In-Network	Out-of-Network
Respite Care[2]	$0 copay; Members diagnosed with dementia may be eligible for a maximum of 12 respite care sessions per year from the network respite care provider.	Not covered

Services with a 2 may require your provider to obtain prior authorization from the plan for in-network or out-of-network benefits.

Required Information

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

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, 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, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

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
1-855-814-6894（TTY：711).

This information is available for free in other languages. Please call our member services number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

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Enrollment Checklist

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 at the number listed on the back cover of this book.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- 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

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- 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 may pay a higher copay for services received by non-contracted providers.