**Medicare Advantage plan with prescription drugs**

# Summary of benefits 2022

**Peoples Health Choices Gold (HMO)**
H1961-017-000

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

Toll-free **1-844-849-2591**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

**www.peopleshealth.com**

PEOPLES HEALTH
*Your **Medicare Health** Team*
A UnitedHealthcare Company

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# Summary of benefits

## January 1st, 2022 - December 31st, 2022

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 Customer Service 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) is a Medicare Advantage HMO 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) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers or pharmacies that are not in our network, the plan may not pay for those services or 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)

## Premiums and Benefits

| | In-Network |
|---|---|
| **Monthly Plan Premium** | There is no monthly premium for this plan. |
| **Annual Medical Deductible** | This plan does not have a deductible. |
| **Maximum Out-of-Pocket Amount (does not include prescription drugs)** | $6,700 annually for Medicare-covered services you receive from in-network providers. |
| | 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.<br><br>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)

## Benefits

| | | In-Network |
|---|---|---|
| **Inpatient Hospital**[2] | | $195 copay per day: for days 1-10<br>$0 copay per day: for days 11 and beyond |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. |
| **Outpatient Hospital**<br><br>Cost sharing for additional plan covered services will apply. | Ambulatory Surgical Center (ASC)[2] | $0 copay for a diagnostic colonoscopy<br>$250 copay otherwise |
| | Outpatient Hospital, including surgery[2] | $0 copay for a diagnostic colonoscopy<br>$250 copay otherwise |
| | Outpatient Hospital Observation Services[2] | $250 copay |
| **Doctor Visits** | Primary Care Provider | $0 copay |
| | Specialists | $30 copay |
| | Virtual Medical Visits | $0 copay; Speak to network telehealth providers using your computer or mobile device. |
| **Preventive Care** | Medicare-covered | $0 copay |
| | | Abdominal aortic aneurysm screening<br>Alcohol misuse counseling<br>Annual “Wellness” visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease (behavioral therapy)<br>Cardiovascular screening<br>Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screening<br>Diabetes screenings and monitoring<br>Hepatitis C screening<br>HIV screening |

## Benefits

| | | In-Network |
|---|---|---|
| | | Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy services<br>Medicare Diabetes Prevention Program (MDPP)<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19<br>"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 | $0 copay; 1 per year |
| **Emergency Care** | | $90 copay ($0 copay for emergency care outside the United States) per visit<br>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" section of this booklet for other costs. |
| **Urgently Needed Services** | | $40 copay<br>($0 copay for urgently needed services outside the United States) per visit |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** | Diagnostic radiology services (e.g. MRI)[2] | $0 copay for each diagnostic mammogram<br>$120 copay otherwise |
| | Lab services[2] | $0 copay |
| | Diagnostic tests and procedures[2] | $10 copay |
| | Therapeutic Radiology[2] | $45 copay per service |
| | Outpatient X-rays[2] | $0 copay at a radiology facility<br>$15 copay at at all other locations |

## Benefits

| | | In-Network |
|---|---|---|
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues | $20 copay |
| | Routine hearing exam | $20 copay; 1 per year |
| | Hearing aid | $500 allowance per ear, maximum benefit of $1,000 every year. |
| **Routine Dental Benefits** | Preventive | $0 copay for covered preventive services |
| | Comprehensive | $50 deductible applies before coverage begins<br>$0 - $217.75 copay for comprehensive dental services |
| | 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 |
| | Eyewear after cataract surgery | $0 copay |
| | Routine eye exam | $35 copay; 1 each year |
| | Routine eyewear | $0 copay every year for a pair of lenses and frames or contact lenses |
| **Mental Health** | Inpatient visit[2] | $195 copay per day: for days 1-9<br>$0 copay per day: for days 10-90 |
| | | Our plan covers 90 days for an inpatient hospital stay. |
| | Outpatient group therapy visit[2] | $40 copay |
| | Outpatient individual therapy visit[2] | $40 copay |
| | Virtual Mental Health Visits | $0 copay; Speak to network telehealth providers using your computer or mobile device. |

## Benefits

| | | In-Network |
|---|---|---|
| **Skilled Nursing Facility (SNF)[2]** | | $0 copay per day: for days 1-20<br>$188 copay per day: for days 21-100 |
| | | Our plan covers up to 100 days in a SNF. |
| **Physical therapy and speech and language therapy visit[2]** | | $20 copay |
| **Ambulance[2]**<br><br>Your provider must obtain prior authorization for non-emergency transportation. | | $280 copay for ground<br>$280 copay for air |
| **Routine Transportation** | | Not covered |
| **Medicare Part B Prescription Drugs**<br><br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Chemotherapy drugs[2] | 20% coinsurance |
| | Other Part B drugs[2] | $0 copay for allergy antigens<br>20% coinsurance for all others |

## 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.

| | | | | |
|---|---|---|---|---|
| **Stage 1: Annual Prescription (Part D) Deductible** | Since you have no deductible for Part D drugs, this payment stage doesn't apply. | | | |
| **Stage 2: Initial Coverage (After you pay your deductible, if applicable)** | **Retail** | | **Mail Order** | |
| | **Standard** | | **Preferred** | **Standard** |
| | **30-day supply** | **90-day supply** | **90-day supply** | **90-day supply** |
| Tier 1: Preferred Generic | $0 copay | $0 copay | $0 copay | $0 copay |
| Tier 2: Generic[3] | $10 copay | $30 copay | $0 copay | $30 copay |
| Tier 3: Preferred Brand | $45 copay | $135 copay | $135 copay | $135 copay |
| Select Insulin Drugs[4] | $35 copay | $105 copay | $105 copay | $105 copay |
| Tier 4: Non-Preferred Drug | $100 copay | $300 copay | $300 copay | $300 copay |
| Tier 5: Specialty Tier | 33% coinsurance | N/A[5] | N/A[5] | N/A[5] |
| **Stage 3: Coverage Gap Stage** | Tier 1 and Tier 2 drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $4,430, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap. | | | |
| **Stage 4: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of:<br><br>□ 5% coinsurance, or<br>□ $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs. | | | |

[3] Tier includes enhanced drug coverage.

[4] For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply of Part D select insulin drugs during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your insulin in the catastrophic stage. This cost-sharing only applies to members who do not qualify for a program that helps pay for your drugs (“Extra Help”).

[5] Limited to a 30-day supply

## Additional Benefits

| | | In-Network |
|---|---|---|
| **Chiropractic Care** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) | $20 copay |
| **Diabetes Management** | Diabetes monitoring supplies[2] | $0 copay for each Medicare-covered blood glucose diabetes monitoring supply from a preferred DME provider.<br>20% coinsurance for each Medicare-covered blood glucose diabetes monitoring supply from other DME providers.<br>Diabetes monitoring supplies must be purchased from a network durable medical equipment provider. |
| | Diabetes Self-management training[2] | $0 copay |
| | Therapeutic shoes or inserts[2] | $10 copay |
| **Durable Medical Equipment (DME) and Related Supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[2] | 20% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | 20% coinsurance |
| **Health Education** | | $0 copay; learn about managing chronic health conditions with telephonic help from clinical staff |
| **Fitness program** | | $0 copay to a network fitness center |
| **Foot Care (podiatry services)** | Foot exams and treatment | $30 copay |
| **Meal Benefit[2]** | | $0 copay; coverage for at-home meal benefit from the network meal provider after an eligible hospital stay. Restrictions apply. |
| **Home Health Care[2]** | | $0 copay |

## Additional Benefits

| | | In-Network |
|---|---|---|
| **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. |
| **NurseLine** | | Speak with a registered nurse (RN) 24 hours a day, 7 days a week. |
| **Occupational Therapy Visit**[2] | | $20 copay |
| **Opioid Treatment Program Services** | | $0 copay |
| **Outpatient Substance Abuse** | Outpatient group therapy visit[2] | $40 copay |
| | Outpatient individual therapy visit[2] | $40 copay |
| **Over-the-Counter (OTC) Products Catalog** | | $40 credit every quarter to purchase approved health products. Order online, over the phone, or by mail through your Over-the-Counter catalog. |
| **Renal Dialysis**[2] | | 20% coinsurance |
| **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. Restrictions apply. |

Services with a 2 may require your provider to obtain prior authorization from the plan.

## Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. A Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's 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 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 does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Member Services number at 1-800-222-8600 for additional information (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, cartas en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-800-222-8600, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 8 a.m. a 8 p.m., hora local, los 7 días de la semana.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions 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.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.