Annual Notice of Changes 2021

Medicare Advantage Plan with Prescription Drugs

Peoples Health Choices Value (HMO)

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?
If not, please let us know so we can keep you informed about your plan.

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

Y0066_ANOC_H1961_018_000_2021_M

Find updates to your plan for next year

This notice provides information about updates to your plan, but it doesn't include all of the details. Throughout this notice you will be directed to **www.peopleshealth.com** to review the details online. All of the below documents will be available online by **October 15, 2020.**

Provider Directory

Review the 2021 Provider Directory online to make sure your providers (primary care provider, specialists, hospitals, etc.) and pharmacies will be in the network next year.

Evidence of Coverage (EOC)

Review your 2021 EOC for details about plan costs and benefits. The EOC 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. It also has information about the Quality Improvement Program, how medical coverage decisions are made and your Rights and Responsibilities as a member.

Would you rather get paper copies?

If you want a paper copy of what is listed above, please contact our Member Services at 1-800-222-8600 (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.

Would you rather get less paper?

Simplify your life with online delivery of plan materials. You can securely access your plan documents online anytime, anywhere. Register at **www.peopleshealth.com** to sign up for online delivery today.

Peoples Health Choices Value (HMO) offered by UnitedHealthcare

Annual Notice of Changes for 2021

You are currently enrolled as a member of Peoples Health Choices Value (HMO).

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 Section 1 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 2021 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 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 www.medicare.gov/plan-compare website.
- 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 don't join another plan by December 7, 2020, you will be enrolled in Peoples Health Choices Value (HMO).
- 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, 2020**

- If you **don't join another plan by December 7, 2020**, you will be enrolled in Peoples Health Choices Value (HMO).
- If you **join another plan by December 7, 2020**, your new coverage will start on January 1, 2021. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in other languages.
- 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.
- Este documento está disponible sin costo en otros idiomas.

- Comuníquese con nuestro Servicio al Cliente al número 1-800-222-8600 para obtener información adicional (los usuarios de TTY deben llamar al 711). El horario es 8 a.m. a 8 p.m., los 7 días de la semana, hora local.
- This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Member Services number at 1-800-222-8600, TTY: 711, 8 a.m. - 8 p.m. local time, 7 days a week, for additional information.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Peoples Health Choices Value (HMO)

- 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 with Medicare.
- When this booklet says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means Peoples Health Choices Value (HMO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Peoples Health Choices Value (HMO) 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 www.peopleshealth.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2020 (this year)	2021 (next year)
Monthly Plan Premium* *Your premium may be higher than this amount. (See Section 1.1 for details.)	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor Office Visits	Primary care visits: You pay a $20 copayment per visit. Specialist visits: You pay a $50 copayment per visit.	Primary care visits: You pay a $20 copayment per visit. Specialist visits: You pay a $50 copayment 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.	You pay a $350 copayment each day for days 1 to 5. $0 copayment for additional Medicare covered days.	You pay a $350 copayment each day for days 1 to 5. $0 copayment for additional Medicare covered days.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Tier 1, Tier 2 and Tier 3 $300 Tier 4 and Tier 5	Deductible: $0 Tier 1, Tier 2 and Tier 3 $300 Tier 4 and Tier 5

Cost	2020 (this year)	2021 (next year)
To find out which drugs are Select Insulin Drugs, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service.	Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: □ Drug Tier 1: Standard retail cost-sharing (in-network) $0 copayment □ Drug Tier 2: Standard retail cost-sharing (in-network) $10 copayment □ Drug Tier 3: Standard retail cost-sharing (in-network) $45 copayment □ Drug Tier 4: Standard retail cost-sharing (in-network) $100 copayment □ Drug Tier 5: Standard retail cost-sharing (in-network) 27% of the total cost	Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: □ Drug Tier 1: Standard retail cost-sharing (in-network) $0 copayment □ Drug Tier 2: Standard retail cost-sharing (in-network) $10 copayment □ Drug Tier 3: Standard retail cost-sharing (in-network) $45 copayment □ Select Insulin Drugs[1]: Standard retail cost-sharing (in-network) $35 copayment □ Drug Tier 4: Standard retail cost-sharing (in-network) $100 copayment □ Drug Tier 5: Standard retail cost-sharing (in-network) 27% of the total cost

[1] For 2021, this plan participates in the Insulin Senior Savings Program 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 covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

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Table of Contents

Section 1: Changes to Benefits and Costs for Next Year

SECTION 1.1: Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly Premium (You must also continue to pay your Medicare Part B premium.)	**$0**	**$0**

- 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.

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	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) 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 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.	$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 www.peopleshealth.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 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 to manage 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 www.peopleshealth.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 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 **2021 Evidence of Coverage.** A copy of the Evidence of Coverage is located on our website at www.peopleshealth.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2020 (this year)	2021 (next year)
Acupuncture for low back pain (Medicare-covered)	You pay a $20 copayment.	You pay a $20 copayment for services provided by a primary care physician. You pay a $50 copayment for services provided by a specialist. See Chapter 4 of the Evidence of Coverage for details.
Ambulance Services	You pay a $235 copayment for each one-way Medicare-covered ground trip. You pay a $235 copayment for each one-way Medicare-covered air trip.	You pay a $250 copayment for each one-way Medicare-covered ground trip. You pay a $250 copayment for each one-way Medicare-covered air trip.

Cost	2020 (this year)	2021 (next year)
Authorization	Your provider must obtain Prior Authorization for some services. Your Prior Authorization requirements include all Medicare-covered services except: Emergency Care, Urgently Needed Services, Emergency Ambulance Services, Opioid Treatment Program Services, Medicare-covered Preventive Services, Outpatient Hospital Observation Services, Medicare-covered Comprehensive Dental, Medicare-covered Eye Exams, Medicare-covered Eyewear, and Medicare-covered Hearing Exams.	The services for which your provider must obtain Prior Authorization have changed. Your Prior Authorization requirements include all Medicare-covered services except: Emergency Care, Urgently Needed Services, Emergency Ambulance Services, Opioid Treatment Program Services, Medicare-covered Preventive Services, Chiropractic Services, Specialist Services, Podiatry Services, Medicare-covered Eyewear, Medicare-covered Comprehensive Dental, Medicare-covered Eye Exams, and Medicare-covered Hearing Exams.
Cardiac Rehabilitation	You pay a $20 copayment.	You pay a $0 copayment.

Cost	2020 (this year)	2021 (next year)
Emergency Care – Worldwide	You pay a $90 copayment for worldwide emergency care and a $50 copayment for worldwide urgently needed care. You are covered for up to $5,000 of emergency and urgently needed care combined. Worldwide emergency ambulance transportation is not covered.	You pay a $0 copayment for worldwide emergency care, worldwide urgently needed care, and worldwide emergency transportation. There is no coverage limit for this benefit.
NurseLine	Not Covered.	You pay a $0 copayment NurseLine services are available, 24 hours a day, seven days a week. Speak to a registered nurse (RN) about your medical concerns and questions.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies - Laboratory Tests	You pay a $20 copayment at a primary care physician office, a $50 copayment at a specialist office, and 30% of the total cost at an outpatient hospital not contracted to provide lab services.	You pay a $0 copayment at a primary care physician office or a lab provider or outpatient hospital contracted to provide lab services, a $50 copayment at a specialist office, and 30% of the total cost at an outpatient hospital not contracted to provide lab services.
Outpatient Substance Abuse Services - Group Therapy Sessions	You pay a $40 copayment at a specialist office. You pay a $50 copayment at an outpatient hospital.	You pay a $40 copayment.

Cost	2020 (this year)	2021 (next year)
Outpatient Substance Abuse Services - Individual Therapy Sessions	You pay a $40 copayment at a specialist office. You pay a $50 copayment at an outpatient hospital.	You pay a $40 copayment.
Telemonitoring Services	You pay a $0 copay for specialized home monitoring, including monitoring equipment, through our contracted telemonitoring vendor.	You pay a $0 copay. Remote monitoring equipment is not covered by our current vendor. If you qualify for one of our clinical digital programs that help you track your health, you will receive additional information about that program in a separate communication.
Urgently Needed Services – Worldwide	You pay a $50 copayment.	You pay a $0 copayment.
Virtual Mental Health Visits	Not Covered	You pay a $0 copayment.

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." **You can get the complete Drug List** by calling Member Services (see the back cover) or visiting our website (www.peopleshealth.com).

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.

- 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 drug that is not on the Drug List (Formulary) or when it is restricted in some way in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the **Evidence of Coverage.**) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have obtained approval for a Drug List (Formulary) exception this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. After the date of expiration on your approval letter, you may need to obtain a new approval in order for the plan to continue to cover the drug, if the drug still requires an exception and you and your doctor feel it is needed. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage or call Member Services.

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 the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” you will receive a “LIS Rider” by September 30, 2020. If you don’t receive it, please call Member Services and ask for the "LIS Rider" to be sent to you.

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 www.peopleshealth.com. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly (Part D) Deductible Stage During this stage, **you pay the full cost** of your Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $0 for drugs on Tier 1 (In-Network Standard Retail 30-Day Supply), $10 for drugs on Tier 2 (In-Network Standard Retail 30-Day Supply), $45 for drugs on Tier 3 (In-Network Standard Retail 30-Day Supply) and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $0 for drugs on Tier 1 (In-Network Standard Retail 30-Day Supply), $10 for drugs on Tier 2 (In-Network Standard Retail 30-Day Supply), $45, for drugs on Tier 3 (In-Network Standard Retail 30-Day Supply), and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible. There is no deductible for Peoples Health Choices Value (HMO) for Select Insulin Drugs. You pay $35 for a one month retail supply for Select Insulin Drugs.

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.**

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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 that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your **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 Drugs**: You pay $0 per prescription. **Tier 2 - Generic Drugs:** You pay $10 per prescription. **Tier 3 - Preferred Brand Drugs:** You pay $45 per prescription. **Tier 4 - Non-Preferred Drugs:** You pay $100 per prescription. **Tier 5 - Specialty Tier Drugs:** You pay 27% of the total cost. _____ Once your total drugs costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 – Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2 - Generic Drugs:** You pay $10 per prescription. **Tier 3 - Preferred Brand Drugs:** You pay $45 per prescription. **Select Insulin Drugs[1]:** You pay $35 per prescription. **Tier 4 - Non-Preferred Drugs:** You pay $100 per prescription. **Tier 5 - Specialty Tier Drugs:** You pay 27% of the total cost. _____ Once your total drugs costs have reached $4,130, you will move to

Stage	2020 (this year)	2021 (next year)
		the next stage (the Coverage Gap Stage).

[1] For 2021, this plan participates in the Insulin Senior Savings Program 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 covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

Changes to the Coverage Gap and Catastrophic Coverage Stages

Our plan offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulin Drugs will be $35 for a one month retail supply.

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 Value (HMO)

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 be enrolled in our Peoples Health Choices Value (HMO).

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 2021 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 2021,** 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 www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, UnitedHealthcare Insurance Company or one of its affiliates offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

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 Value (HMO).
- 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 Value (HMO).
- 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 to December 7.** The change will take effect on January 1, 2021.

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, 2021, 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, 2021. 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 Louisiana Senior Health Insurance Information Program (SHIIP).

Louisiana Senior Health Insurance Information Program (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. Louisiana Senior Health Insurance Information Program (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 Louisiana Senior Health Insurance Information Program (SHIIP) at 1-800-259-5300**.**

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).
- **Help from your state's pharmaceutical assistance program.** Louisiana has a program called Louisiana Department of Health that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your **Evidence of Coverage**).
- **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 ADAP in your State. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP in your State. You can find your State's ADAP contact information in Chapter 2 of the **Evidence of Coverage.**

Section 6: Questions?

SECTION 6.1: Getting Help from Peoples Health Choices Value (HMO)

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 8 a.m. - 8 p.m. local time, 7 days a week. Calls to these numbers are free.

Read your 2021 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 2021. For details, look in the 2021 **Evidence of Coverage** for Peoples Health Choices Value (HMO). 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 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 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).

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 (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 www.medicare.gov/plan-compare).

Read Medicare & You 2021

You can read the **Medicare & You 2021** 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 (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.

Peoples Health Choices Value (HMO) Member Services:

Call **1-800-222-8600**

Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week.

Write Three Lakeway CTR, 3838 N Causeway BLVD, STE 2200 Metairie, LA 70002

Website **www.peopleshealth.com**