**TexanPlus Classic (HMO)** ***offered by*** **SelectCare Health Plans, Inc.**

# Annual Notice of Changes for 2017

You are currently enrolled as a member of TexanPlus Classic (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.**

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## Additional Resources

- This information is available for free in other languages.
- Please contact our Member Services number at (800) 958-2707 for additional information. (TTY users should call 711.) Hours are seven days a week from 8 a.m. to 8 p.m.
- Member Services also has free language interpreter services available for non-English speakers.
- Esta información está disponible gratuitamente en otros idiomas. Por favor, póngase en contacto con nuestro número de servicios al miembro al (800) 958-2707 para obtener información adicional. (Los usuarios de TTY deben llamar 711). Horas son 8:00 a.m. a 8:00 p.m. en la zona horaria local, 7 días a la semana.
- Servicios para Miembros también dispone de intérprete de lengua servicios disponibles para quienes no hablan inglés.
- We must provide information in a way that works for you (in languages other than English, Braille, and Large Print or other alternate formats, etc.).
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) 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 on the individual requirement for MEC.

## About TexanPlus Classic (HMO)

- TexanPlus® HMO is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPlus® HMO depends on contract renewal.
- When this booklet says "we," "us," or "our," it means SelectCare Health Plans, Inc. When it says "plan" or "our plan," it means TexanPlus Classic (HMO).

## Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

### Important things to do:

- □ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 1.1 and Section 1.5 for information about benefit and cost changes for our plan.
- □ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- □ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors 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? How do the total costs compare to other Medicare coverage options?
- □ **Think about whether you are happy with our plan.**

### If you decide to <u>stay</u> with TexanPlus Classic (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything.

### If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

## Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for TexanPlus Classic (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium may be higher or lower than this amount. See Section 1.1 for details. | $0.00 | $0.00 |
| **Maximum out-of-pocket amount** <br> This is the most you will pay out-of-pocket for your covered Part A and Part B services. <br> (See Section 1.2 for details.) | $4,900.00 | $4,900.00 |
| **Doctor office visits** | Primary care visits: $0.00 per visit <br> Specialist visits: $45.00 per visit | Primary care visits: $0.00 per visit <br> Specialist visits: $45.00 per visit |
| **Inpatient hospital stays** <br> 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. | For each Medicare-covered hospital stay: <br> Days 1 - 5: $260.00 copay per day <br> Days 6 - 90: $0.00 copay per day. | For each Medicare-covered hospital stay: <br> Days 1 - 5: $255.00 copay per day <br> Days 6 - 90: $0.00 copay per day. |
| **Part D prescription drug coverage** <br> (Standard Cost-Share for a 30-day supply) <br> (See Section 1.6 for details.) | Copayment during the Initial Coverage Stage: <br> Drug Tier 1: $5.00 <br> Drug Tier 2: $10.00 <br> Drug Tier 3: $45.00 | Copayment during the Initial Coverage Stage: <br> Drug Tier 1: $5.00 <br> Drug Tier 2: $10.00 <br> Drug Tier 3: $45.00 |

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| | Drug Tier 4: $85.00<br>Drug Tier 5: 33% | Drug Tier 4: $85.00<br>Drug Tier 5: 33% |
| **Part D prescription drug coverage**<br>(Preferred Cost-Share for a 30-day supply)<br>(See Section 1.6 for details) | Copayment during the Initial Coverage Stage:<br>Drug Tier 1: $0.00<br>Drug Tier 2: $5.00<br>Drug Tier 3: $35.00<br>Drug Tier 4: $75.00<br>Drug Tier 5: 33% | Copayment during the Initial Coverage Stage:<br>Drug Tier 1: $0.00<br>Drug Tier 2: $5.00<br>Drug Tier 3: $35.00<br>Drug Tier 4: $75.00<br>Drug Tier 5: 33% |

# *Annual Notice of Changes* for 2017
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# SECTION 1 Changes to Benefits and Costs for Next Year

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $0.00 | $0.00 |

- 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 | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. | $4,900.00 | $4,900.00<br>Once you have paid $4,900.00 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.TexanPlusDFW.com. You may also call Member Services for

updated provider information or to ask us to mail you a Provider Directory. **Please review the 2017 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, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will 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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.TexanPlusDFW.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2017 Pharmacy 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 *2017 Evidence of Coverage.*

| | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Dental Services** | **In-Network**<br>$15.00 copay for preventive dental visits.<br><br>**Benefit Maximum**<br>Limit on number of visits – see the 2016 EOC for details.<br><br>Limit on number of visits – see the 2016 EOC for details. | **In-Network**<br>$5.00 copay for preventive dental visits.<br><br>**Benefit Maximum**<br>$500.00 maximum benefit per year for comprehensive dental visits.<br><br>$500.00 maximum benefit per year for preventive dental visits. |
| **Emergency Care** | **Benefit Maximum**<br>$25,000.00 maximum worldwide emergent coverage or 60 days of care, whichever is reached first. | **Benefit Maximum**<br>$20,000.00 maximum worldwide emergent coverage or 60 days of care, whichever is reached first. |
| **Inpatient Hospital Care** | **In-Network**<br>For each Medicare-covered hospital stay:<br>Days 1 - 5: $260.00 copay per day<br>Days 6 - 90: $0.00 copay per day. | **In-Network**<br>For each Medicare-covered hospital stay:<br>Days 1 - 5: $255.00 copay per day<br>Days 6 - 90: $0.00 copay per day. |
| **Inpatient Mental Health Care** | **In-Network**<br>For each Medicare-covered hospital stay:<br>Days 1 - 5: $260.00 copay per day<br>Days 6 - 190: $0.00 copay per day. | **In-Network**<br>For each Medicare-covered hospital stay:<br>Days 1 - 5: $255.00 copay per day<br>Days 6 - 190: $0.00 copay per day. |
| **Long Term Acute Care** | **In-Network**<br>Long Term Acute Care (LTAC) is only a covered benefit when in-network. The | **In-Network**<br>Long Term Acute Care (LTAC) is only a covered benefit when in-network. The LTAC coverage will be as follows, in-network: |

| | 2016 (this year) | 2017 (next year) |
|---|---|---|
| | LTAC coverage will be as follows, in-network: $260.00 copayment per day, days 1 thru 5 and $0.00 copayment per day, days 6 thru 60 per LTAC admit for the first 60 days. This co-payment is waived if the LTAC confinement is a transfer from an inpatient acute care setting.<br>90 days of Medically Necessary LTAC related hospitalization for each Benefit Period to include Medically Necessary inpatient hospital acute care days, the Benefit Period as defined by Medicare Part A, and up to 60 lifetime reserve days to a maximum of 150 days.<br>$283 per day copayment for days 61-90 per Benefit Period; $566 each lifetime reserve day. | $255.00 copayment per day, days 1 thru 5 and $0.00 copayment per day, days 6 thru 60 per LTAC admit for the first 60 days. This co-payment is waived if the LTAC confinement is a transfer from an inpatient acute care setting.<br>90 days of Medically Necessary LTAC related hospitalization for each Benefit Period to include Medically Necessary inpatient hospital acute care days, the Benefit Period as defined by Medicare Part A, and up to 60 lifetime reserve days to a maximum of 150 days.<br>$283 per day copayment for days 61-90 per Benefit Period; $566 each lifetime reserve day. |
| **Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers** | **In-Network**<br>$250.00 copay for each Medicare-covered outpatient hospital facility visit. | **In-Network**<br>$235.00 copay for each Medicare-covered outpatient hospital facility visit. |
| **Pulmonary Rehabilitation Services** | **In-Network**<br>$40.00 copay for Medicare-covered Pulmonary Rehabilitation Services. | **In-Network**<br>$30.00 copay for Medicare-covered Pulmonary Rehabilitation Services. |

| | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Screening for lung cancer with low dose computed tomography (LDCT)** | **In-Network**<br>Not Available | **In-Network**<br>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. |

## 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 in this envelope.

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 **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (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 received a formulary exception in 2016, depending on the drug, most of the formulary exceptions may be granted for a minimum of 1 year beginning on the date the formulary exception was originally approved.

**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 get "Extra Help" and haven't received this insert by October 1, 2016 please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 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 enclosed *Evidence of Coverage*.)

### Changes to the Deductible Stage

| Stage | 2016 (this year) | 2017 (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*.

| | 2016 (this year) | 2017 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.<br>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network | Your cost for a one-month supply at a network pharmacy:<br>Tier 1: Standard cost-sharing: You pay $5.00 per prescription<br>Preferred cost-sharing: You pay $0.00 per prescription<br>Tier 2: Standard cost-sharing: You pay $10.00 per prescription | Your cost for a one-month supply at a network pharmacy:<br>Tier 1: Standard cost-sharing: You pay $5.00 per prescription<br>Preferred cost-sharing: You pay $0.00 per prescription<br>Tier 2: Standard cost-sharing: You pay $10.00 per prescription |

| | 2016 (this year) | 2017 (next year) |
|---|---|---|
| pharmacy. For information about the costs for a long-term supply at a network pharmacy that offers preferred cost-sharing, or for mail-order prescriptions look in Chapter 6, Section 5 of your *Evidence of Coverage*.<br><br>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. | Preferred cost-sharing: You pay $5.00 per prescription<br><br>Tier 3: Standard cost-sharing: You pay $45.00 per prescription<br><br>Preferred cost-sharing: You pay $35.00 per prescription<br><br>Tier 4: Standard cost-sharing: You pay $85.00 per prescription<br><br>Preferred cost-sharing: You pay $75.00 per prescription<br><br>Tier 5: Standard cost-sharing: You pay 33% per prescription<br><br>Preferred cost-sharing: You pay 33% per prescription | Preferred cost-sharing: You pay $5.00 per prescription<br><br>Tier 3: Standard cost-sharing: You pay $45.00 per prescription<br><br>Preferred cost-sharing: You pay $35.00 per prescription<br><br>Tier 4: Standard cost-sharing: You pay $85.00 per prescription<br><br>Preferred cost-sharing: You pay $75.00 per prescription<br><br>Tier 5: Standard cost-sharing: You pay 33% per prescription<br><br>Preferred cost-sharing: You pay 33% per prescription |
| | Once your total drug costs have reached $3,310 you will move to the next stage (the Coverage Gap Stage). | Once your total drug costs have reached $3,700 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 Other Changes

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| Emergency Care | If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment | If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for |

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| | is waived for the emergency room visit.<br><br>If you have surgery as an outpatient within 24 hours for the same condition, the copayment is waived for the emergency room visit and the applicable outpatient surgical cost share applies.<br><br>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. | the emergency room visit.<br><br>If you have surgery as an outpatient within 24 hours for the same condition, the copayment is waived for the emergency room visit and the applicable outpatient surgical cost share applies.<br><br>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized.<br><br>If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.<br><br>Currently, Medicare and Medicare Advantage programs do not recognize Free Standing |

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| | | Emergency Rooms, which are distinct and separate from hospitals, as providers qualified to furnish emergency services. Services received at freestanding ERs will not be covered by TexanPlus Classic (HMO) and will be the financial responsibility of the member. |
| Urgently Needed Care | In addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, Part D prescription drugs, and Medicare Part B prescription drugs, as described in this Benefit Chart. If you are admitted to the inpatient acute level of care from an Urgent Care Center, the above cost shares are waived and the Inpatient Hospital care cost shares applies. | In addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, Part D prescription drugs, and Medicare Part B prescription drugs, as described in this Benefit Chart.<br><br>If you are admitted to the inpatient acute level of care from an Urgent Care Center, the above cost shares are waived and the Inpatient Hospital care cost shares applies.<br><br>Urgently needed care may be received from |

| Cost | 2016 (this year) | 2017 (next year) |
|---|---|---|
| | | both contracted and non-contracted urgent care centers, as long as the urgent care center accepts Medicare. Services received from an urgent care center that does not accept Medicare will be the financial responsibility of the member. |

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 – If you want to stay in TexanPlus Classic (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 stay enrolled as a member of our plan for 2017.

### Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, SelectCare Health Plans, Inc. 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 TexanPlus Classic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from TexanPlus Classic (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 7.1 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 4 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, 2017.

### 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 are 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, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 5 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 Texas, the SHIP is called Health Information Counseling and Advocacy Program (HICAP).

Health Information Counseling and Advocacy Program (HICAP) 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. Health Information Counseling and Advocacy Program (HICAP) 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 Health Information Counseling and

Advocacy Program (HICAP) at (800) 252-9240. You can learn more about Health Information Counseling and Advocacy Program (HICAP) by visiting their website (http://www.dads.state.tx.us/).

## SECTION 6 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.** Texas has a program called Texas HIV State Pharmacy Assistance Program (SPAP) 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 Section 5 of this booklet).
- **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 Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (800) 255-1090.

## SECTION 7 Questions?

### Section 7.1 – Getting Help from TexanPlus Classic (HMO)

Questions? We're here to help. Please call Member Services at (800) 958-2707. (TTY only, call 711). We are available for phone calls seven days a week from 8 a.m. to 8 p.m. Calls to these numbers are free.

### Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for TexanPlus Classic (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 included in this envelope.

### Visit our Website

You can also visit our website at www.TexanPlusDFW.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 7.2 – 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 (http://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 http://www.medicare.gov and click on "Find health & drug plans").

### Read *Medicare & You 2017*

You can read the *Medicare & You 2017* 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 (http://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.

# Discrimination is Against the Law

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today's Options® PFFS, and Today's Options® PPO (hereinafter, the Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- 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)
- 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 Civil Rights Coordinator.

If you believe that the Plan 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: Civil Rights Coordinator, Your Plan Name, P.O. Box 742608, Houston, Texas 77274, c/o Appeals and Grievances, 1-866-422-1690 (TTY users call 711), Fax: 1-800-817-3516, Email: AGMailbox@UniversalAmerican.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

**Spanish:**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711).

**Chinese:**
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 1-888-736-7442 (TTY: 711)。

**Russian:**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-736-7442 (телетайп: 711).

**French:**
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-736-7442 (ATS: 711).

**Vietnamese:**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-736-7442 (TTY: 711).

**Korean:**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-736-7442 (TTY: 711) 번으로 전화해 주십시오.

**Arabic:**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-736-7442 ( رقم هاتف الصم والبكم :711).

**Italian:**
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-736-7442 (TTY: 711).

**Yiddish:**
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-888-736-7442 (TTY: 711).

**Bengali:**
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরষবা উপলব্ধ আছ। ফোন করুন ১-888-736-7442 (TTY: 711)।

**Urdu:**
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں 1-888-736-7442 (TTY: 711). کال کریں ۔

**Polish:**
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-736-7442 (TTY: 711).

**Tagalog:**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-736-7442 (TTY: 711).

**Greek:**
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-736-7442 (TTY: 711).

**Albanian:**
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-736-7442 (TTY: 711).

**Hindi:**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-736-7442 (TTY: 711) पर कॉल करें।