Today's Options® PFFS

2017 Summary of Benefits

Select Counties in Maine and New York:

Maine: Cumberland and Sagadahoc.
New York: Albany, Allegany, Broome, Cayuga, Chemung, Chenango, Cortland, Erie, Fulton, Genesee, Herkimer, Madison, Montgomery, Oneida, Onondaga, Ontario, Oswego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Tioga, Warren, and Washington.

January 1, 2017 — December 31, 2017

Y0067_PRE_H2816_SBKit01_0816 CMS Accepted 09/12/2016

Notes

Summary of Benefits

January 1, 2017 - December 31, 2017

This is a summary of drug and health services covered by Today's Options® PFFS.

Today's Options PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options PFFS depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the Evidence of Coverage (EOC) by calling us or visiting our website. See back page for contact information.

Who can join?

To join Today's Options Premier Plus 650B (PFFS), Today's Options Premier Plus 250A (PFFS), Today's Options Premier 300 (PFFS), and Today's Options Premier 200 (PFFS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Maine and New York:

Maine: Cumberland and Sagadahoc.

New York: Albany, Allegany, Broome, Cayuga, Chemung, Chenango, Cortland, Erie, Fulton, Genesee, Herkimer, Madison, Montgomery, Oneida, Onondaga, Ontario, Oswego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Tioga, Warren, and Washington.

Which doctors, hospitals, and pharmacies can I use?

Today's Options Premier Plus 650B (PFFS), Today's Options Premier Plus 250A (PFFS), Today's Options Premier 300 (PFFS), and Today's Options Premier 200 (PFFS), are Private Fee-for-Service plans. Our plans have a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. You can also use providers that are not in our network (as long as the provider accepts the plan's terms and conditions of payment and participates in the Medicare program).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

For more information on our network of doctors, hospitals, pharmacies, and other providers, please call us or visit our website at www.TodaysOptions.com. See back page for contact information.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use our plan's formulary (list of covered drugs) to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Medicare & You Handbook

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 http://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. This document is available in other formats such as braille, large print or audio.

Summary of Benefits

January 1, 2017 - December 31, 2017

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
PLAN BASICS				
Monthly Plan Premium	$39.00 **What You Should Know:** You must continue to pay your Medicare Part B premium.	$106.00 **What You Should Know:** You must continue to pay your Medicare Part B premium.	$0.00 **What You Should Know:** You must continue to pay your Medicare Part B premium.	$53.00 **What You Should Know:** You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	$0 **What You Should Know:** This plan does not offer a Part B Premium Reduction.	$0 **What You Should Know:** This plan does not offer a Part B Premium Reduction.	$0 **What You Should Know:** This plan does not offer a Part B Premium Reduction.	$0 **What You Should Know:** This plan does not offer a Part B Premium Reduction.
Annual Deductible	$0 **What You Should Know:** This plan does not have a deductible.	$0 **What You Should Know:** This plan does not have a deductible.	$0 **What You Should Know:** This plan does not have a deductible.	$0 **What You Should Know:** This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 Combined **What You Should Know:** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. The combined limit is the most you pay for copays, coinsurance and other costs for a combination of in-network and out-of-network medical services.	$3,400 Combined **What You Should Know:** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. The combined limit is the most you pay for copays, coinsurance and other costs for a combination of in-network and out-of-network medical services.	$6,700 Combined **What You Should Know:** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. The combined limit is the most you pay for copays, coinsurance and other costs for a combination of in-network and out-of-network medical services.	$3,400 Combined **What You Should Know:** Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. The combined limit is the most you pay for copays, coinsurance and other costs for a combination of in-network and out-of-network medical services.

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Inpatient Hospital Coverage	**In-Network:** $295 Copay per day (Day 1 - 5) $0 Copay per day (Day 6 and beyond) **Out-of-Network:** $300 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond) **What You Should Know:** Our plan covers an unlimited number of days for an inpatient hospital stay.	**In-Network:** $450 Copay per stay **Out-of-Network:** $250 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond) **What You Should Know:** Our plan covers an unlimited number of days for an inpatient hospital stay.	**In-Network:** $260 Copay per day (Day 1 - 6) $0 Copay per day (Day 7 and beyond) **Out-of-Network:** $300 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond) **What You Should Know:** Our plan covers an unlimited number of days for an inpatient hospital stay.	**In-Network:** $450 Copay per stay **Out-of-Network:** $250 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond) **What You Should Know:** Our plan covers an unlimited number of days for an inpatient hospital stay.
Doctor Visits				
Primary Care Physician	**In-Network:** $10 Copay **Out-of-Network:** $25 Copay	**In-Network:** $0 Copay **Out-of-Network:** $10 Copay	**In-Network:** $5 Copay **Out-of-Network:** $15 Copay	**In-Network:** $0 Copay **Out-of-Network:** $10 Copay
Specialist	**In-Network:** $35 Copay **Out-of-Network:** $60 Copay	**In-Network:** $25 Copay **Out-of-Network:** $35 Copay	**In-Network:** $30 Copay **Out-of-Network:** $50 Copay	**In-Network:** $25 Copay **Out-of-Network:** $35 Copay

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Preventive Care Abdominal Aortic Aneurysm Screening; Alcohol Misuse Counseling; Bone Mass Measurement; Breast Cancer Screening (mammogram); Cardiovascular Disease (behavioral therapy); Cardiovascular Screenings; Cervical and Vaginal Cancer Screening; Colorectal Cancer Screenings (Colonoscopy, Fecal Occult Blood Test, Flexible Sigmoidoscopy); Depression Screening; Diabetes Screenings; Glaucoma Screening; HIV Screening; Lung Cancer Screening; Medical Nutrition Therapy Services; Obesity Screening and Counseling; Prostate Cancer Screenings (PSA); Sexually Transmitted Infections Screening 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); Annual Wellness Visit	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Any additional preventive services approved by Medicare during the contract year will be covered. For Colorectal Cancer Screenings, please note that a colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this benefit grid.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Any additional preventive services approved by Medicare during the contract year will be covered. For Colorectal Cancer Screenings, please note that a colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this benefit grid.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Any additional preventive services approved by Medicare during the contract year will be covered. For Colorectal Cancer Screenings, please note that a colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this benefit grid.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Any additional preventive services approved by Medicare during the contract year will be covered. For Colorectal Cancer Screenings, please note that a colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this benefit grid.

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Emergency Care				
Emergency Care	$75 Copay	$75 Copay	$75 Copay	$75 Copay
Worldwide Emergency	20% of the cost $20,000 Benefit Maximum **What You Should Know:** For Emergency Care; if you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency is subject to a $20,000 maximum plan coverage or 60 days of care, whichever is reached first. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. There is also no coverage for medication purchases while outside of the United States.	20% of the cost $20,000 Benefit Maximum **What You Should Know:** For Emergency Care; if you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency is subject to a $20,000 maximum plan coverage or 60 days of care, whichever is reached first. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. There is also no coverage for medication purchases while outside of the United States.	20% of the cost $20,000 Benefit Maximum **What You Should Know:** For Emergency Care; if you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency is subject to a $20,000 maximum plan coverage or 60 days of care, whichever is reached first. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. There is also no coverage for medication purchases while outside of the United States.	20% of the cost $20,000 Benefit Maximum **What You Should Know:** For Emergency Care; if you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency is subject to a $20,000 maximum plan coverage or 60 days of care, whichever is reached first. There is no worldwide coverage for care outside of the emergency room or emergency hospital admission. There is also no coverage for medication purchases while outside of the United States.
Urgently Needed Services	$35 Copay **What You Should Know:** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	$35 Copay **What You Should Know:** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	$35 Copay **What You Should Know:** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	$35 Copay **What You Should Know:** If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Diagnostic Services/Labs/ Imaging (costs may vary based on place of service)				
Diagnostic Radiology (MRIs, CT scans)	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost
Diagnostic Tests	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Diagnostic Procedures	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Lab Services	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Outpatient X-Rays	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost
Therapeutic Radiology	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost
Related Medical Supplies	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Hearing Services				
Hearing Exams				
Medicare Covered	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost
Routine Hearing Screening	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. This plan covers one routine hearing screening per year.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. This plan covers one routine hearing screening per year.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. This plan covers one routine hearing screening per year.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Medicare covers diagnostic hearing and balance exams if your doctor or other health care provider orders these tests to see if you need medical treatment. Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. This plan covers one routine hearing screening per year.
Dental Services				
Comprehensive Dental Visits				
Medicare Covered	**In-Network:** $35 Copay **Out-of-Network:** $60 Copay	**In-Network:** $25 Copay **Out-of-Network:** $35 Copay	**In-Network:** $30 Copay **Out-of-Network:** $50 Copay	**In-Network:** $25 Copay **Out-of-Network:** $35 Copay

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Vision Services				
Eye Exams				
Medicare Covered	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Routine Eye Exams (Refraction)	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Glaucoma Screenings	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Eyewear				
Medicare Covered	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 1 routine eye exam (refraction) every year. Eyewear is limited to one pair of glasses or contacts after cataract surgery.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 1 routine eye exam (refraction) every year. Eyewear is limited to one pair of glasses or contacts after cataract surgery.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 1 routine eye exam (refraction) every year. Eyewear is limited to one pair of glasses or contacts after cataract surgery.	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 1 routine eye exam (refraction) every year. Eyewear is limited to one pair of glasses or contacts after cataract surgery.

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Mental Health Services				
Inpatient Hospital Visit	**In-Network:** $295 Copay per day (Day 1 - 5) $0 Copay per day (Day 6 and beyond) **Out-of-Network:** $300 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond)	**In-Network:** $450 Copay per stay **Out-of-Network:** $250 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond)	**In-Network:** $260 Copay per day (Day 1 - 6) $0 Copay per day (Day 7 and beyond) **Out-of-Network:** $300 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond)	**In-Network:** $450 Copay per stay **Out-of-Network:** $250 Copay per day (Day 1 - 7) $0 Copay per day (Day 8 and beyond)
Outpatient Individual Therapy	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost
Outpatient Group Therapy	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost
Partial Hospitalization	**In-Network:** $55 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	**In-Network:** $55 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	**In-Network:** $55 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	**In-Network:** $55 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

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Skilled Nursing Facility (SNF)	In-Network: $0 Copay per day (Day 1 - 20) $150 Copay per day (Day 21 - 100) Out-of-Network: $0 Copay per day (Day 1 - 20) $200 Copay per day (Day 21 - 100) What You Should Know: Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a facility (acute inpatient, long term care acute or SNF) and ends when you haven't received any inpatient facility care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	In-Network: $0 Copay per day (Day 1 - 20) $75 Copay per day (Day 21 - 100) Out-of-Network: $0 Copay per day (Day 1 - 20) $150 Copay per day (Day 21 - 100) What You Should Know: Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a facility (acute inpatient, long term care acute or SNF) and ends when you haven't received any inpatient facility care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	In-Network: $0 Copay per day (Day 1 - 20) $100 Copay per day (Day 21 - 100) Out-of-Network: $0 Copay per day (Day 1 - 20) $150 Copay per day (Day 21 - 100) What You Should Know: Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a facility (acute inpatient, long term care acute or SNF) and ends when you haven't received any inpatient facility care for 60 consecutive days. There is no limit to the number of benefit periods you may have.	In-Network: $0 Copay per day (Day 1 - 20) $75 Copay per day (Day 21 - 100) Out-of-Network: $0 Copay per day (Day 1 - 20) $150 Copay per day (Day 21 - 100) What You Should Know: Our plan covers up to 100 days per benefit period in a SNF. A Benefit Period begins the first day you go into a facility (acute inpatient, long term care acute or SNF) and ends when you haven't received any inpatient facility care for 60 consecutive days. There is no limit to the number of benefit periods you may have.

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Rehabilitation Services				
Outpatient Services:				
Cardiac (Heart) Rehab Services	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $35 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost
Occupational Therapy Visit	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $35 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost
Physical, Speech, Language Therapy	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $35 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost
Pulmonary Rehabilitation	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $15 Copay **Out-of-Network:** 25% of the cost
Ambulance	$300 Copay **What You Should Know:** The cost share is not waived if you are admitted for inpatient hospital care.	$300 Copay **What You Should Know:** The cost share is not waived if you are admitted for inpatient hospital care.	$300 Copay **What You Should Know:** The cost share is not waived if you are admitted for inpatient hospital care.	$300 Copay **What You Should Know:** The cost share is not waived if you are admitted for inpatient hospital care.
Transportation	Not Covered	Not Covered	Not Covered	Not Covered

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Foot Care (podiatry services)	**In-Network:** $50 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**In-Network:** $35 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**In-Network:** $45 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**In-Network:** $35 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/Supplies				
Diabetes Monitoring Supplies	**In-Network:** 0%-20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 0%-20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 0%-20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 0%-20% of the cost **Out-of-Network:** 25% of the cost
Diabetes Self-Management Training	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost
Therapeutic Shoes or Inserts	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost
Durable Medical Equipment	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Prosthetic Devices	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost **What You Should Know:** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions. The plan maintains a list of the preferred brand diabetic monitoring supplies that are subject to lower cost-sharing.	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost **What You Should Know:** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions. The plan maintains a list of the preferred brand diabetic monitoring supplies that are subject to lower cost-sharing.	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost **What You Should Know:** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions. The plan maintains a list of the preferred brand diabetic monitoring supplies that are subject to lower cost-sharing.	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost **What You Should Know:** Covered diabetes supplies include: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions. The plan maintains a list of the preferred brand diabetic monitoring supplies that are subject to lower cost-sharing.
Wellness Programs				
Enhanced Disease Management	$0 Copay	$0 Copay	$0 Copay	$0 Copay
24/7 Health Line	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Medicare Part B Drugs				
Part B Drugs such as Chemotherapy	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost
Other Part B Drugs	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)		TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)		TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
PRESCRIPTION DRUG BENEFITS						
DEDUCTIBLE	$0		$0		Our plan does not cover Part D prescription drugs.	Our plan does not cover Part D prescription drugs.
INITIAL COVERAGE STAGE	You pay these copays or coinsurance amounts until your total yearly drug cost reaches $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.		You pay these copays or coinsurance amounts until your total yearly drug cost reaches $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
Preferred Retail Cost-Share (In-Network)	30-Day Retail	90-Day Retail	30-Day Retail	90-Day Retail		
Tier 1: Preferred Generic	$2.00	$5.00	$0.00	$0.00		
Tier 2: Generic	$7.00	$17.50	$5.00	$12.50		
Tier 3: Preferred Brand	$37.00	$92.50	$35.00	$87.50		
Tier 4: Non-Preferred Drugs	$90.00	$225.00	$75.00	$187.50		
Tier 5: Specialty Tier Drugs	33%	N/A	33%	N/A		
Standard Retail Cost-Share (In-Network)	30-Day Retail	90-Day Retail	30-Day Retail	90-Day Retail		
Tier 1: Preferred Generic	$7.00	$17.50	$5.00	$12.50		
Tier 2: Generic	$12.00	$30.00	$10.00	$25.00		
Tier 3: Preferred Brand	$47.00	$117.50	$45.00	$112.50		
Tier 4: Non-Preferred Drugs	$100.00	$250.00	$85.00	$212.50		
Tier 5: Specialty Tier Drugs	33%	N/A	33%	N/A		

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)		TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)		TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
	What You Should Know: You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan's cost of the drug minus the copay or co-insurance for drugs purchased out-of-network until total yearly drug costs reach $3,700. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement.		**What You Should Know:** You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. You will be reimbursed up to the plan's cost of the drug minus the copay or co-insurance for drugs purchased out-of-network until total yearly drug costs reach $3,700. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement.		Our plan does not cover Part D prescription drugs.	Our plan does not cover Part D prescription drugs.
Preferred Mail Order Cost Sharing	30-Day Supply	90-Day Supply	30-Day Supply	90-Day Supply		
Tier 1: Preferred Generic	$2.00	$2.00	$0.00	$0.00		
Tier 2: Generic	$7.00	$7.00	$5.00	$5.00		
Tier 3: Preferred Brand	$37.00	$74.00	$35.00	$70.00		
Tier 4: Non-Preferred Drugs	$90.00	$180.00	$75.00	$150.00		
Tier 5: Specialty Tier Drugs	33%	N/A	33%	N/A		

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
	What You Should Know: 90-day supply of Tier 1 and Tier 2 prescription drugs for a 30-day copay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day copays. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and copays.	**What You Should Know:** 90-day supply of Tier 1 and Tier 2 prescription drugs for a 30-day copay; 90-day supply of Tier 3 and Tier 4 prescription drugs for two 30-day copays. Available only from a preferred mail service pharmacy and filled during the initial coverage stage. See the Formulary and Evidence of Coverage (EOC) for availability and copays.		
GAP COVERAGE STAGE	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your out-of-pocket costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your out-of-pocket costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Our plan does not cover Part D prescription drugs.	Our plan does not cover Part D prescription drugs.

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
CATASTROPHIC COVERAGE STAGE	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost; or • $3.30 copay for generics (including brand drugs treated as generic) or • $8.25 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost; or • $3.30 copay for generics (including brand drugs treated as generic) or • $8.25 copayment for all other drugs.	Our plan does not cover Part D prescription drugs.	Our plan does not cover Part D prescription drugs.
OTHER INFORMATION	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.		
ADDITIONAL COVERED BENEFITS				
Chiropractic Care	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan only covers manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan only covers manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan only covers manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	**In-Network:** $20 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Our plan only covers manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Home Health Care	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.	**In-Network:** $0 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include part-time or intermittent Skilled Nursing and home health-aide services including physical therapy, occupational therapy, and speech therapy, medical and social services, medical equipment & supplies.
Hospice	**What You Should Know:** You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	**What You Should Know:** You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	**What You Should Know:** You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	**What You Should Know:** You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Outpatient Substance Abuse				
Individual Therapy	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost
Group Therapy	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $40 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $30 Copay **Out-of-Network:** 25% of the cost

	TODAY'S OPTIONS PREMIER PLUS 650B (PFFS)	TODAY'S OPTIONS PREMIER PLUS 250A (PFFS)	TODAY'S OPTIONS PREMIER 300 (PFFS)	TODAY'S OPTIONS PREMIER 200 (PFFS)
Outpatient Surgery and Services				
Ambulatory surgical center	**In-Network:** $250 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $75 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $150 Copay **Out-of-Network:** 25% of the cost	**In-Network:** $75 Copay **Out-of-Network:** 25% of the cost
Outpatient hospital	**In-Network:** $300 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient facility setting.	**In-Network:** $150 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient facility setting.	**In-Network:** $200 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient facility setting.	**In-Network:** $150 Copay **Out-of-Network:** 25% of the cost **What You Should Know:** Covered services include surgery, heart catheterizations, oncology related services, respiratory services, wound care, infusion therapies and other therapeutic procedures done in an outpatient facility setting.
Renal Dialysis	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 25% of the cost

Today's Options® PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PFFS depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711).

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)。

A Private Fee-for-Service plan is not Medicare supplement insurance. Providers who do not contract with our plan are not required to see you except in an emergency.

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Multi-language Interpreter Services

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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).

Multi-language Interpreter Services

Bengali:
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরষবা উপলব্ধ আোছ। 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।

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 18200, Austin, TX 78760-8200, 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:
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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).

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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।

Today's Options® PFFS

Contact Us

For more information, please call us at the phone number below or visit us at www.TodaysOptions.com.

- Not yet a member? Please call us toll-free at 1-866-418-1923, TTY users should call 711. Your call may be answered by a licensed agent.
- Already a member? Please call us at Member Services at 1-866-568-8921, TTY users should call 711.

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m., Eastern Time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m., Eastern Time.

Formularies and Directories

- You can find our plan's complete formulary (list of Part D prescription drugs) and online Find a Drug search tool, along with any restrictions, on our website at www.Universal-American-Medicare.com/TodaysOptionsFindADrug. Or, call us and we will send you a copy.
- You can find our plan's online Find a Pharmacy search tool on our website at www.Universal-American-Medicare.com/TodaysOptionsFindAPharmacy.
- You can find our plan's Provider Directory and online Find a Provider search tool on our website at www.Universal-American-Medicare.com/TodaysOptionsFindAProvider. Or, call us and we will send you a copy of the Provider Directory.