TexanPlus Value (HMO) offered by SelectCare of Texas, Inc.

Annual Notice of Changes for 2018

You are currently enrolled as a member of *TexanPlus 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 Sections 1.1 and 1.4 for information about benefit and cost changes for our plan.

☐ 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 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 https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 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 want to **keep** *TexanPlus Value (HMO)*, you don't need to do anything. You will stay in *TexanPlus 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, 2017**
   - If you **don't join by December 7, 2017**, you will stay in *TexanPlus Value (HMO)*.
   - If you join by December 7, 2017, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at (866) 230-2513 for additional information. (TTY users should call 711.) Hours are seven days a week 8 a.m. to 8 p.m.
- 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.).
- **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.

About *TexanPlus Value (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 of Texas, Inc.* When it says "plan" or "our plan," it means *TexanPlus Value (HMO)*.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for *TexanPlus Value (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	2017 (this year)	2018 (next year)
Monthly plan premium (See Section 1.1 for details.)	$0.00	$0.00
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.)	$3,000.00	$3,000.00
Doctor office visits	Primary care visits: $0.00 per visit Specialist visits: $20.00 per visit	Primary care visits: $0.00 per visit Specialist visits: $20.00 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**.**	$300.00 copay for each Medicare-covered hospital stay.	$300.00 copay for each Medicare-covered hospital stay.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0.00	$0.00
Part B Rebate	$70.00	$80.00

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	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$3,000.00	$3,000.00 Once you have paid $3,000.00 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.TexanPlus.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 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.
- 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 and managing your care.

Section 1.4 – 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 *2018 Evidence of Coverage*.

	2017 (this year)	2018 (next year)
Ambulance Services	**In-Network** $50.00 copay for Medicare-covered ambulance services per one-way trip.	**In-Network** $250.00 copay for Medicare-covered ambulance services per one-way trip.
Durable Medical Equipment and Related Supplies	**In-Network** 10% of the cost for Medicare-covered durable medical equipment.	**In-Network** 20% of the cost for Medicare-covered durable medical equipment.
Emergency Care	$75.00 copay for each Medicare-covered emergency room visit. $75.00 copay for emergency services outside of the U.S.	$100.00 copay for each Medicare-covered emergency room visit. $100.00 copay for emergency services outside of the U.S.

	2017 (this year)	2018 (next year)
Health and Wellness Education Programs	**In-Network** Not Available	**In-Network** $0.00 copay for an annual physical exam.
Medical Nutritional Therapy	**In-Network** Not Available	**In-Network** $0.00 copay for supplemental medical nutritional therapy.
Medicare Diabetes Prevention Program (MDPP)	**In-Network** Not Available	**In-Network** $0.00 copay for Medicare-covered MDPP benefit.
Services to Treat Kidney Disease and End Stage Renal Disease	**In-Network** $30.00 copay for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.	**In-Network** 20% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.

SECTION 2 Administrative Changes

Cost	2017 (this year)	2018 (next year)
Dental – Supplemental Preventive Dental Services	Services from In Network and OON Providers were covered under this Benefit.	Only services from In Network Dentists will be covered. The dentist must be part of the Careington network to be covered.
Immunizations	A vaccine and/or immunization must be considered a Part B drug by Medicare in order to be covered under this benefit. Some vaccinations, such as the Shingles vaccination, are considered Part D Drugs and are not covered under this benefit. If your physician performs additional diagnostic or surgical	A vaccine and/or immunization must be considered a Part B drug by Medicare in order to be covered under this benefit. Some vaccinations and their administration, such as the Shingles vaccination, are considered Part D Drugs and are not covered under this benefit.

Cost	2017 (this year)	2018 (next year)
	procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.	If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Inpatient Hospital Care	Cost shares are applied starting on the first day of admission and do not include the date of discharge. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing that you would pay at a network hospital.	Cost shares are applied starting on the first day of admission and do not include the date of discharge. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing that you would pay at a network hospital. Inpatient stays at a Long Term Acute Care Facility are covered according to the Long Term Acute Care benefit section in this chapter. Medicare hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hosptial) is considered a new admission.
Medical Nutritional Therapy	Medicare Covered Medical Nutritional Therapy is limited to 3 hours of one-on-one counseling services during your	Medicare Covered Medical Nutritional Therapy is limited to 3 hours of one-on-one counseling services during your

Cost	2017 (this year)	2018 (next year)
	first year that you receive medical nutrition therapy services under Medicare and 2 hours each year after that for members with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant.	first year that you receive medical nutrition therapy services under Medicare and 2 hours each year after that for members with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant. As a supplemental benefit, Plan covers • 1 additional hour of one-on-one counseling for members with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant. • 3 hours of one-on-one counseling for members with medical need for Medical Nutritional Therapy.
Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers	Services include surgical services, minor surgical services, heart caths, oncology related services, wound care, infusion therapies, respiratory services and other therapeutic procedures done in an outpatient facility setting. Additional coinsurance applies for Medicare-covered Part B prescription drugs. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery the above cost share is waived and the Inpatient Hospital care cost share applies.	Services include surgical services, minor surgical services, heart caths, oncology related services, wound care, infusion therapies, respiratory services and other therapeutic procedures done in an outpatient facility setting. Additional coinsurance applies for Medicare-covered Part B prescription drugs. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery the above cost share is waived and the Inpatient Hospital care cost share applies. If you receive services at a physician's office but they are owned by a hospital and considered to be an outpatient department of the

Cost	2017 (this year)	2018 (next year)
		hospital, the outpatient Surgery cost share will apply.
Physician/Practitioner Services, Including Doctor's Office Visits	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, eyeglasses and contacts after cataract surgery and Medicare Part B prescription drugs, as described in this Benefit Chart. For other physician services not listed here, please see the appropriate section of this Benefit Chart for details. Medicare Covered Chiropractic services provided by a PCP or specialist, when applicable, are covered under the Chiropractic Benefit and will take the Chiropractic Cost share. Medicare Covered Podiatry services provided by a PCP or specialist, when applicable, are covered under the Podiatry Benefit and will take the Podiatry Cost share. Medicare Covered Outpatient Rehabilitation services provided by a PCP or specialist, when applicable, are covered under the Outpatient Rehabilitation Benefit and will take the Outpatient Rehabilitation Cost share.	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, eyeglasses and contacts after cataract surgery and Medicare Part B prescription drugs, as described in this Benefit Chart. If your physician's practice is owned by a hospital system, they may be considered to be an outpatient department of the hospital, and cost shares for their services may fall under the "Outpatient Surgery and Services performed at an Outpatient Hospital or Ambulatory Surgery Center" benefit sections. Please see that section for applicable cost shares. For other physician services not listed here, please see the appropriate section of this Benefit Chart for details. Medicare Covered Chiropractic services provided by a PCP or specialist, when applicable, are covered under the Chiropractic Benefit and will take the Chiropractic Cost share. Medicare Covered Outpatient Rehabilitation services provided

Cost	2017 (this year)	2018 (next year)
	Medicare Covered Cardiac/ Pulmonary Rehabilitation services provided by a PCP or specialist, when applicable, are covered under the Cardiac/ Pulmonary Rehabilitation Benefit and will take the Cardiac/ Pulmonary Rehabilitation Cost share.	by a PCP or specialist, when applicable, are covered under the Outpatient Rehabilitation Benefit and will take the Outpatient Rehabilitation Cost share. Medicare Covered Cardiac/ Pulmonary Rehabilitation services provided by a PCP or specialist, when applicable, are covered under the Cardiac/ Pulmonary Rehabilitation Benefit and will take the Cardiac/ Pulmonary Rehabilitation Cost share.
Podiatry	The Podiatry Services cost share will apply to Medicare Covered Podiatry services provided by a Podiatrist, PCP or other specialist, as appropriate. 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 and Medicare Part B prescription drugs, as described in this Benefit Chart.	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 and Medicare Part B prescription drugs, as described in this Benefit Chart.
Services to Treat Kidney Disease and Conditions	Staff-assisted home dialysis using nurses to assist ESRD beneficiaries is not included in the ESRD PPS and is not a Medicare covered service. If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other	Staff-assisted home dialysis using nurses to assist ESRD beneficiaries is not included in the ESRD PPS and is not a Medicare covered service. See "Inpatient Hospital Care" for cost shares applicable to inpatient dialysis treatments.

Cost	2017 (this year)	2018 (next year)
	medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.	If your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
Transportation	Routine Transportation is a trip to a scheduled medical appointment within a defined service area when the need for transport is not based on medical necessity and can be met through a van, sedan or other non-ambulance vehicle. Trips must be arranged through the contracted transportation vendor and must be scheduled 3 days in advance of needed services. Members who require non-emergent transportation by an ambulance because transportation by other means is counter indicated (could endanger the person's health) may be able to get services under the Ambulance Benefit, if the plan deems the service to be medically necessary. See the "Ambulance services" benefit in this Medical Benefit Grid for details, including the applicable cost share.	Routine Transportation is a trip to a scheduled medical appointment within a defined service area when the need for transport is not based on medical necessity and can be met through a van, sedan or other non-ambulance vehicle. Trips must be arranged through the contracted transportation vendor and must be scheduled 3 days in advance of needed services. Trips to the pharmacy after a medical appointment will be covered but will count as a one-way trip. Members who require non-emergent transportation by an ambulance because transportation by other means is counter indicated (could endanger the person's health) may be able to get services under the Ambulance Benefit, if the plan deems the service to be medically necessary. See the "Ambulance services" benefit in this Medical Benefit Grid for details, including the applicable cost share.

Cost	2017 (this year)	2018 (next year)
Vision Care	Medicare-Covered Vision Benefit is limited to office visits and non-radiologic vision testing. Facility and/or specialist cost share will apply to other services performed, including surgical services. In addition to the cost-shares above, there will be a copay and/or coinsurance for outpatient diagnostic tests and therapeutic services and Medicare Part B prescription drugs, as described in this Benefit Chart. For other physician services not listed here, please see the appropriate section of this Benefit Chart for details. Fittings for eyeglasses and contacts are covered under the eyewear benefit and subject to the same diagnosis restrictions.	Medicare-Covered Vision Benefit is limited to office visits and non-radiologic vision testing. Facility and/or specialist cost share will apply to other services performed, including surgical services. In addition to the cost-shares above, there will be a copay and/or coinsurance for outpatient diagnostic tests and therapeutic services and Medicare Part B prescription drugs, as described in this Benefit Chart. For other physician services not listed here, please see the appropriate section of this Benefit Chart for details. Fittings for eyeglasses and contacts are covered under the eyewear benefit and subject to the same diagnosis restrictions. Laser Cataract Surgery and Laser Vision Surgery are not covered services.
Worldwide Emergency Coverage	Cost shares paid for Worldwide Emergent Coverage does not apply to your Maximum Out Of Pocket Limits. This plan offers Worldwide coverage for Emergency Care, not generally covered by Medicare. This benefit includes emergency care as described above until you are medically stabilized for transport or discharge up to a maximum of	Cost shares paid for Worldwide Emergent Coverage does not apply to your Maximum Out Of Pocket Limits. This plan offers Worldwide coverage for Emergency Care, not generally covered by Medicare. This benefit includes emergency care as described above until you are medically stabilized for transport or discharge up to a maximum of $20,000 or 60 days per calendar

Cost	2017 (this year)	2018 (next year)
	$20,000 or 60 days per calendar year.	year. It does not include worldwide coverage for Urgent Care.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in TexanPlus 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 stay enrolled as a member of our plan for 2018.

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 2018 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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (SHIP) (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 https://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 of Texas, Inc.* offers other Medicare health 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 Value (HMO)*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *TexanPlus 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 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, 2018.

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 8, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 8, 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 Kidney Health Care Program (KHC) 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).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance Texas HIV Medication Program (THMP). Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. 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 Value (HMO)

Questions? We're here to help. Please call Member Services at (866) 230-2513. (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 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for *TexanPlus 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 included in this envelope.

Visit Our Website

You can also visit our website at *www.TexanPlus.com*. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

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 (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2018*

You can read *Medicare & You 2018* 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 (https://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, Today's Options® PPO, and Today's Options® HMO 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*

English:
ATTENTION: If you speak another language, 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)。

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।