



2018 Summary of Benefits

Select Counties in: Houston-Beaumont Area

Houston: Austin, Brazoria, Fort Bend, Galveston (zip codes: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592), Harris, Liberty, Montgomery, and Waller.

Beaumont: Chambers, Hardin, Jefferson, and Orange.

January 1, 2018 — December 31, 2018

2018 Summary of Benefits

January 1, 2018 – December 31, 2018

H4506
Plan 003

This is a summary of drug and health services covered by TexanPlus HMO – City of Houston Group.

TexanPlus® HMO is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPlus® HMO 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 TexanPlus HMO – City of Houston Group, 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 **Houston – Beaumont**: Austin, Brazoria, Fort Bend, Galveston (zip codes: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592), Harris, Liberty, Montgomery, and Waller. **Beaumont**: Chambers, Hardin, Jefferson, and Orange.

Which doctors, hospitals, and pharmacies can I use?

TexanPlus HMO – City of Houston Group is a Health Maintenance Organization (HMO) plan. That means you must generally receive care through our network of local doctors, hospitals, and other providers (except emergency care or out-of-area urgently needed services). If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

For more information on our network of doctors, hospitals, pharmacies, and other providers, please call us or visit our website at www.TexanPlus.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, 2018 – December 31, 2018

TEXANPLUS (HMO)

PLAN BASICS

Monthly Plan Premium	\$23.00 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.
Annual Medical Deductible	\$0 What You Should Know: This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	\$3,400 What You Should Know: Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. This is the most you pay for copays, coinsurance and other costs for in-network medical services for the year. The amounts you pay for your Part D prescription drugs do not count towards your maximum out-of-pocket amount.

COVERED MEDICAL AND HOSPITAL BENEFITS

- ① Services may require prior authorization.
- ② Services may require a referral from your doctor.

Inpatient Hospital Coverage ①②

\$325 Copay per stay

What You Should Know:

Our plan covers an unlimited number of days for an inpatient hospital stay.

<p>Outpatient Hospital Coverage, Surgery and Services ①②</p> <p>Ambulatory surgical center Outpatient hospital</p>	<p>\$50 Copay \$150 Copay</p> <p>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.</p>
<p>Doctor Visits ①②</p> <p>Primary Care Physician Specialist</p>	<p>\$0 Copay \$35 Copay</p>
<p>Preventive Care</p> <p>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</p>	<p>\$0 Copay</p> <p>What You Should Know: Medical Nutritional Therapy covers nutritional diagnostic, therapy, and counseling services for disease management furnished by a registered dietitian or nutrition professional. Plan covers one additional hour per year for members with diabetes and renal disease and three additional hours per year for members with medical necessity including but not limited to obesity and related comorbidities, as determined by care management.</p> <p>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 in this benefit grid.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

<p>Emergency Care Emergency Care Worldwide Emergency</p>	<p>\$100 Copay \$100 Copay \$20,000 Benefit Maximum</p> <p>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.</p> <p>Worldwide Emergency is subject to a \$20,000 maximum plan coverage or 60 days of care, whichever is reached first.</p> <p>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.</p>
<p>Urgently Needed Services</p>	<p>\$25 Copay</p> <p>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.</p>
<p>Diagnostic Services/Labs/Imaging ①② Diagnostic Radiology (MRIs, CT scans) Diagnostic Tests Diagnostic Procedures Lab Services* Outpatient X-Rays Therapeutic Radiology Related Medical Supplies</p>	<p>10% of the cost \$0-\$25 Copay \$0 Copay \$0 Copay \$0 Copay 10% of the cost 20% of the cost</p> <p>What You Should Know: Prior authorization required to be covered except for x-rays and some lab procedures, when done in free-standing facilities.</p> <p>Cardiac Stress Tests have a copay of \$25, whereas all other diagnostic procedures/tests have a copay of \$0.</p>

<p>Hearing Services ①② Medicare Covered Hearing Exams</p>	<p>\$35 Copay 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.</p>
<p>Dental Services ①② Comprehensive Dental Visits Medicare Covered Periodontics, Oral Surgery and Restorative Services Preventive Dental Visits Oral Exams, Prophylaxis (Cleaning), Fluoride Treatment and Dental X-Rays</p>	<p>\$35 Copay \$0 Copay \$5 Copay What You Should Know: Medicare covers dental services related to medical treatment. Our plan covers a maximum of \$500 for comprehensive dental services and \$500 for preventive dental services each year.</p>

<p>Vision Services ①</p> <p>Eye Exams Medicare Covered Routine Eye Exams (Refraction) Glaucoma Screenings Eyewear Medicare Covered Contact Lenses, Eye Glasses, Eye Glass Lenses, Eye Glass Frames</p>	<p>\$0 Copay \$0 Copay \$0 Copay \$0 Copay \$0 Copay (covered up to \$100 every two years)</p> <p>What You Should Know: Our plan covers up to 1 routine eye exam (refraction) every year.</p> <p>Enhanced benefits for eyewear to include coverage for contact lenses, eye glasses (lenses and frames), eye glass lenses and eye glass frames up to a maximum benefit of \$100.00 every two years, not related to post cataract surgery. Medicare covered eyewear is limited to one pair of glasses or contacts after cataract surgery.</p>
<p>Mental Health Services ①②</p> <p>Inpatient Hospital Visit Outpatient Individual Therapy Outpatient Group Therapy Partial Hospitalization</p>	<p>\$325 Copay per stay \$35 Copay \$20 Copay \$35 Copay</p> <p>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.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>\$0 Copay per day (Days 1 - 20) \$100 Copay per day (Days 21 - 100)</p> <p>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.</p>

TEXANPLUS (HMO)

<p>Physical Therapy Occupational Therapy Visit Physical, Speech, Language Therapy</p>	<p>\$35 Copay \$35 Copay \$150 Copay What You Should Know: The cost share is not waived if you are admitted for inpatient hospital care.</p>
<p>Transportation ⓘ</p>	<p>\$0 Copay What You Should Know: 30 one-way trips per plan year for non-emergency, scheduled appointments to or from approved locations in the plan's service area. Routine transportation services must be scheduled 3 days in advance of needed services. If you are given a prescription that needs to be filled, you can be transported to a pharmacy immediately following your doctor's appointment using an additional one-way trip from your benefits.</p>
<p>Medicare Part B Drugs ⓘ Part B Drugs such as Chemotherapy Other Part B Drugs</p>	<p>10% of the cost 0% - 10% of the cost What You Should Know: \$0 cost share for respiratory compound medications administered through a nebulizer provided by a preferred vendor. 10% for all other Medicare Part B drugs.</p>

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG DEDUCTIBLE	\$0
INITIAL COVERAGE STAGE	You pay these copays or coinsurance amounts until your total yearly drug cost reaches \$5,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.
Standard Retail Cost-Share (In-Network)	90-Day Retail
Tier 1: Preferred Generic	\$10.00
Tier 2: Generic	\$15.00
Tier 3: Preferred Brand	\$37.50
Tier 4: Non-Preferred Drugs	\$100.00
Tier 5: Specialty Tier Drugs	\$137.50
	Not Available
	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 \$5,000. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement.
Preferred Mail Order Cost Sharing	90-Day Supply
Tier 1: Preferred Generic	\$10.00
Tier 2: Generic	\$15.00
Tier 3: Preferred Brand	\$40.00
Tier 4: Non-Preferred Drugs	\$55.00
Tier 5: Specialty Tier Drugs	\$75.00
	Not Available
	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. Because there is no coverage gap for this plan, this payment stage does not apply.
GAP COVERAGE STAGE	

TEXANPLUS (HMO)

<p>CATASTROPHIC COVERAGE STAGE</p>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,000, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost; or • \$3.35 copay for generics (including brand drugs treated as generic) or • \$8.35 copayment for all other drugs.
<p>OTHER INFORMATION</p>	<p>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.</p>
<p>ADDITIONAL COVERED BENEFITS</p>	
<p>Rehabilitation Services ①②</p>	
<p>Outpatient Services: Cardiac (Heart) Rehab Services Pulmonary Rehabilitation</p>	<p>\$35 Copay \$30 Copay \$35 Copay</p>
<p>Foot Care (podiatry services) ①②</p>	<p>What You Should Know: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.</p>
<p>Medical Equipment/Supplies ①② Diabetes Monitoring Supplies Diabetes Self-Management Training Therapeutic Shoes or Inserts Durable Medical Equipment Prosthetic Devices</p>	<p>0%-20% of the cost \$0 Copay 20% of the cost 20% of the cost 20% 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.</p>

<p>Wellness Programs Silver&Fit® Fitness Program Fitness Facility Membership Home Fitness Kit Enhanced Disease Management 24/7 Health Line</p>	<p>\$25 Copay \$10 Copay \$0 Copay \$0 Copay</p> <p>What You Should Know: The Silver&Fit® Exercise and Healthy Aging Program offers Members the option of a fitness facility membership or a home fitness kit for those who cannot get to a fitness facility or prefer to work out at home. Copays are for an annual membership fee. Limit 2 home fitness kits per year.</p> <p>Services that call for an added fee are not part of the Silver&Fit program. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein.</p>
<p>Chiropractic Care ①②</p>	<p>\$20 Copay</p> <p>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).</p>
<p>Home Health Care ①②</p>	<p>\$0 Copay</p> <p>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.</p>
<p>Hospice</p>	<p>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.</p>
<p>Outpatient Substance Abuse ①② Individual Therapy Group Therapy</p>	<p>\$35 Copay \$20 Copay</p>
<p>Renal Dialysis ①②</p>	<p>\$30 Copay</p>

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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.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

*Medicare-approved lab work.

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>

Multi-Language Interpreter Services

ATTENTION: If you speak a language other than English, 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).

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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 করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরম্বা উপলব্ধ। ফোন করুন ১-৮৮৮-৭৩৬-৭৪৪২ (TTY: 711)।

Urdu:

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

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।

Contact Us



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

- Not yet a member? Please call us toll-free at 1-866-556-4607, TTY users should call 711. Your call may be answered by a licensed agent.
- Already a member? Please call us at 1-866-230-2513, 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., in your local time zone. Calls made after hours may leave a voicemail, and your call will be returned within one business day.
- From February 15 to September 30, you can also call us 7 days a week from 8:00 a.m. to 8:00 p.m., in your local time zone. Calls made after hours or on Saturday—Sunday may leave a voicemail, and your call will be returned within one business day.



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/TexanPlusFindADrug. 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/TexanPlusFindAPharmacy.
- You can find our plan's Provider Directory and online **Find a Provider** search tool on our website at www.Universal-American-Medicare.com/TexanPlusFindAProvider. Or, call us and we will send you a copy of the Provider Directory.