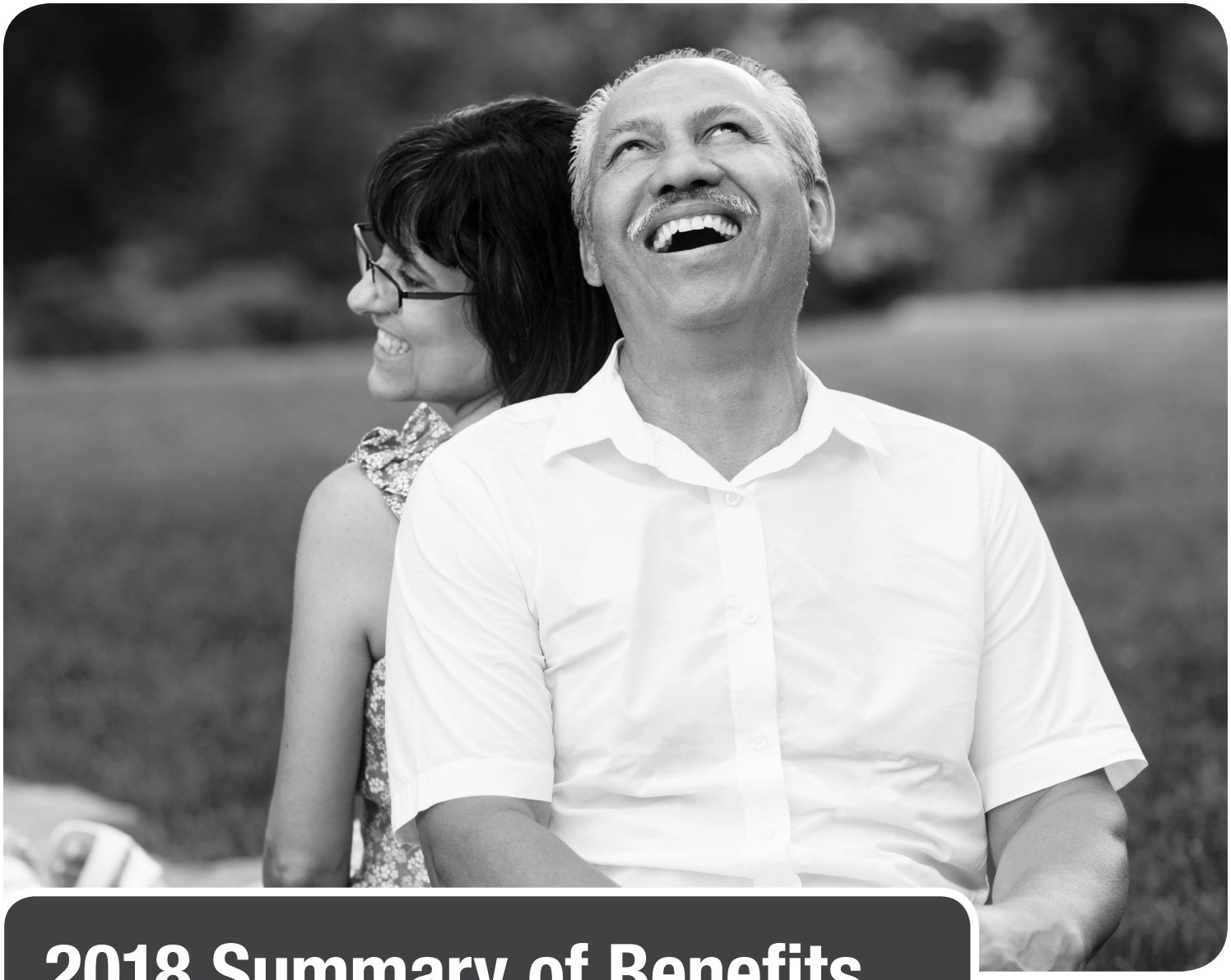
TexanPlus® HMO-POS

A WellCare Company



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

Y0067_PRE_H4506-POS_SBKit45_0817 CMS Accepted 09/10/2017

Notes

2018 Summary of Benefits

January 1, 2018 - December 31, 2018

H4506
Plan 029

This is a summary of drug and health services covered by TexanPlus Choice (HMO-POS).

TexanPlus® HMO-POS is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPlus® HMO-POS 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 Choice (HMO-POS), 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: 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.

Which doctors, hospitals, and pharmacies can I use?

TexanPlus Choice (HMO-POS) is a Health Maintenance Organization (HMO) with a Point-of-Service (POS) option. Our plan has 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 have the flexibility to choose providers out-of-network without an authorization or referral (as long as the provider accepts the plan's terms and conditions of payment and participates in the Medicare program) but you may pay a higher cost share.

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.TexanPlusPOS.com. See back page for contact information.

How will I determine my drug costs?

Our plan groups 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 CHOICE (HMO-POS)
PLAN BASICS	
Monthly Plan Premium	$0.00 **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)	$6,700 In-Network / $10,000 Out-of-Network **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.
COVERED MEDICAL AND HOSPITAL BENEFITS	
① Services may require prior authorization when received in-network. ② Services may require a referral from your doctor.	
Inpatient Hospital Coverage ①②	**In-Network:** $250 Copay per day (Days 1 - 5) $0 Copay per day (Days 6 and beyond) **Out-of-Network:** 40% of the cost **What You Should Know:** Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage, Surgery and Services ①②	
Ambulatory surgical center	**In-Network:** $200 Copay **Out-of-Network:** 40% of the cost

	TEXANPLUS CHOICE (HMO-POS)
Outpatient hospital	**In-Network:** $240 Copay **Out-of-Network:** 40% 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.
Doctor Visits ①②	
Primary Care Physician	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Specialist	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
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:** 40% of the cost **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. 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. Any additional preventive services approved by Medicare during the contract year will be covered.

	TEXANPLUS CHOICE (HMO-POS)
Emergency Care	
Emergency Care	$80 Copay
Worldwide Emergency	$80 Copay $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.
Diagnostic Services/Labs/Imaging ①② (costs may vary based on place of service)	
Diagnostic Radiology (MRIs, CT scans)	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost
Diagnostic Tests	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Diagnostic Procedures	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Lab Services*	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Outpatient X-Rays	**In-Network:** $15 Copay **Out-of-Network:** 40% of the cost

	TEXANPLUS CHOICE (HMO-POS)
Therapeutic Radiology	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost
Related Medical Supplies	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost **What You Should Know:** Prior authorization required to be covered except for x-rays and some lab procedures, when done in free-standing facilities.
Hearing Services ①②	
Medicare Covered Hearing Exams	**In-Network:** $0 Copay **Out-of-Network:** 40% 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.
Dental Services ②	
Medicare Covered Comprehensive Dental Visits	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
Preventive Dental Visits	
Oral Exams, Prophylaxis (Cleaning), Fluoride Treatment and Dental X-Rays	**In-Network:** $15 Copay **Out-of-Network:** Not Covered **What You Should Know:** Medicare covers dental services related to medical treatment. Our plan covers a maximum of $500 for preventive dental services each year.

	TEXANPLUS CHOICE (HMO-POS)
Vision Services	
Eye Exams	
Medicare Covered	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Routine Eye Exams (Refraction)	**In-Network:** $0 Copay **Out-of-Network:** Not Covered
Glaucoma Screenings	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Eyewear	
Medicare Covered	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Contact Lenses, Eye Glasses, Eye Glass Lenses, Eye Glass Frames	**In-Network:** $0 Copay (covered up to $100 every two years) **Out-of-Network:** Not Covered **What You Should Know:** Our plan covers up to 1 routine eye exam (refraction) every year. 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.
Mental Health Services ①②	
Inpatient Hospital Visit	**In-Network:** $250 Copay per day (Days 1 - 5) $0 Copay per day (Days 6 and beyond) **Out-of-Network:** 40% of the cost

	TEXANPLUS CHOICE (HMO-POS)
Outpatient Individual Therapy	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
Outpatient Group Therapy	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
Partial Hospitalization	**In-Network:** $55 Copay **Out-of-Network:** 40% 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.
Skilled Nursing Facility (SNF) ①②	**In-Network:** $0 Copay per day (Days 1 - 20) $150 Copay per day (Days 21 - 100) **Out-of-Network:** 40% of the cost **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.
Physical Therapy	
Occupational Therapy Visit	**In-Network:** $35 Copay **Out-of-Network:** 40% of the cost
Physical, Speech, Language Therapy	**In-Network:** $35 Copay **Out-of-Network:** 40% of the cost

	TEXANPLUS CHOICE (HMO-POS)	
Ambulance	$250 Copay **What You Should Know:** The cost share is not waived if you are admitted for inpatient hospital care.	
Transportation	Not Covered	
Medicare Part B Drugs ①		
Part B Drugs such as Chemotherapy	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost	
Other Part B Drugs	**In-Network:** 0% - 20% of the cost **Out-of-Network:** 40% of the cost **What You Should Know:** **In-Network:** $0 Cost share for respiratory compound medications administered through a nebulizer provided by a preferred vendor. 20% for all other Medicare Part B drugs.	
PRESCRIPTION DRUG BENEFITS		
PRESCRIPTION DRUG DEDUCTIBLE	$0	
INITIAL COVERAGE STAGE	You pay these copays or coinsurance amounts until your total yearly drug cost reaches $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	
Standard Retail Cost-Share (In-Network)	30-Day Retail	90-Day Retail
Tier 1: Preferred Generic	$0.00	$0.00
Tier 2: Generic	$5.00	$12.50
Tier 3: Preferred Brand	$40.00	$100.00
Tier 4: Non-Preferred Drugs	$80.00	$200.00
Tier 5: Specialty Tier Drugs	33%	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 $3,750. You will likely have to pay the pharmacy's full charge for the drugs and submit documentation to receive reimbursement.	

	TEXANPLUS CHOICE (HMO-POS)	
Preferred Mail Order Cost Sharing	30-Day Supply	90-Day Supply
Tier 1: Preferred Generic	$0.00	$0.00
Tier 2: Generic	$5.00	$5.00
Tier 3: Preferred Brand	$40.00	$80.00
Tier 4: Non-Preferred Drugs	$80.00	$160.00
Tier 5: Specialty Tier Drugs	33%	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.	
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 $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your out-of-pocket costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. The chart below shows how much it will cost you.	
	30-Day Retail	90-Day Retail
Tier 1: Preferred Generic - All Drugs Covered	$0.00	$0.00
CATASTROPHIC COVERAGE STAGE	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: • 5% of the cost; or • $3.35 copay for generics (including brand drugs treated as generic) or • $8.35 copayment for all other 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.	

ADDITIONAL COVERED BENEFITS	
Rehabilitation Services ①②	
Outpatient Services:	
Cardiac (Heart) Rehab Services	**In-Network:** $35 Copay **Out-of-Network:** 40% of the cost
Pulmonary Rehabilitation	**In-Network:** $30 Copay **Out-of-Network:** 40% of the cost
Foot Care (podiatry services)	**In-Network:** $40 Copay **Out-of-Network:** 40% 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 ①②	
Diabetes Monitoring Supplies	**In-Network:** 0%-20% of the cost **Out-of-Network:** 40% of the cost
Diabetes Self-Management Training	**In-Network:** $0 Copay **Out-of-Network:** 40% of the cost
Therapeutic Shoes or Inserts	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost
Durable Medical Equipment	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost

	TEXANPLUS CHOICE (HMO-POS)
Prosthetic Devices	**In-Network:** 20% of the cost **Out-of-Network:** 40% 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	
Silver&Fit® Fitness Program	
Fitness Facility Membership	$25 Copay
Home Fitness Kit	$10 Copay
Enhanced Disease Management	$0 Copay
24/7 Health Line	$0 Copay
	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. 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.
Chiropractic Care ①②	**In-Network:** $20 Copay **Out-of-Network:** 40% 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).

	TEXANPLUS CHOICE (HMO-POS)
Home Health Care ①②	**In-Network:** $0 Copay **Out-of-Network:** 40% 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.
Outpatient Substance Abuse ①②	
Individual Therapy	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
Group Therapy	**In-Network:** $40 Copay **Out-of-Network:** 40% of the cost
Renal Dialysis ①	**In-Network:** 20% of the cost **Out-of-Network:** 40% of the cost
Annual Physical Exam	**In-Network:** $0 Copay **Out-of-Network:** Not Available **What You Should Know:** The Annual Physical Exam is a comprehensive physical examination and evaluation of the status of chronic diseases. It involves an actual physical exam and could include some testing and health history.

TexanPlus® HMO-POS is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPlus® HMO-POS 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.

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).

Y0067_PRE_MLINondiscrim_0717 CMS Accepted 07/22/2017
H4868_PRE_MLINondiscrim_0717 CMS Accepted 07/22/2017

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 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।

TexanPlus® HMO-POS
A WellCare Company

Contact Us

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