Texas HealthSpring

A Medicare Advantage Plan

Evidence Of Coverage

For City of Houston Retirees

Your Texas HealthSpring Medicare HMO Plan Benefits and Services

May 1, 2005 – December 31, 2005

This booklet gives the details about your Medicare Health Coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Texas HealthSpring Customer Service:

For help or information, please call Customer Service Monday through Friday, 8 a.m. to 5 p.m.

Calls to these numbers are free:

Local: 832-553-3480

Toll Free: 1-800-280-8888

TTY users should call 1-877-893-1504

Texas HealthSpring, a Medicare Advantage Organization with a Medicare contract.

HSTXCOH004 03/05

Welcome to the Texas HealthSpring Medicare HMO Plan!

The Texas HealthSpring Medicare HMO Plan is an HMO for people with Medicare

Now that you are enrolled in the Plan, you are getting your care through Texas HealthSpring. Texas HealthSpring Medicare HMO Plan ("Plan"), an HMO, is offered by Texas HealthSpring. **(The Plan is *not* a "Medigap" or Supplemental Medicare Insurance Policy.)**

This booklet explains how to get your Medicare services through the Plan

This booklet, together with your enrollment form and any Amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of the Plan. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from May 1, 2005 through December 31, 2005.

You are still covered by Original Medicare, but you are getting your Medicare services as a Member of the Plan. This booklet gives you the details, including:

- What is covered in the Plan and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health Plan and when you get care.
- What to do if you are unhappy about something related to getting your Covered Services.
- How to leave the Plan, including your choices for continuing Medicare if you leave.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health Plan. You can call or write to us at any time (Section 1 of this booklet tells how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our Members to tell about their experiences with the Plan. If you are contacted, we hope you will participate in a Member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Table of Contents

SECTION 1. Summary of Benefits

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Important Information		
1 - Premium and Other Important Information The Out-of-Pocket Maximum does not include physician services	• You pay the Medicare Part B premium of $78.20 each month.	• You continue to pay your Medicare Part B Premium of $78.20 each month and pay any contribution required by your employer. • There is a $1,500 maximum out-of-pocket limit every year for the following plan services : • Inpatient Hospital Care • Inpatient Mental Health Care • Skilled Nursing Facility • Home Health Care • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Substance Abuse Care • Outpatient Services • Ambulance Services • Emergency Care • Urgently Needed Care • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetic Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays and Lab Services • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Cardiac Rehabilitation Services • Renal Dialysis
2 - Doctor and Hospital Choice *(For more information, see Emergency - #16 and Urgently Needed Care - #17.)*	• You may go to any doctor, Specialist or Hospital that accepts Medicare.	• You must go to network doctors, Specialists and Hospitals. • You need a Referral to go to network Hospitals and certain doctors, including Specialists for certain services.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Inpatient Care		
3 - Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	• You pay for each benefit period (3): - Days 1 - 60: an initial deductible of $912 - Days 61 - 90: $228 each day - Days 91 - 150: $456 each lifetime reserve day (4) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	You pay: • $275 for each Medicare-covered stay at a network Hospital. • You are covered for unlimited days each benefit period.
4 - Inpatient Mental Health Care	• You pay the same deductible and Copayments as inpatient Hospital care (above) except Medicare beneficiaries may only receive 190 days in a psychiatric Hospital in a lifetime.	You pay: • $275 for each Medicare-covered stay at a network hospital. • There is a 190-day lifetime limit in a psychiatric Hospital. • The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when enrolling in a Medicare Advantage Plan.
5 - Skilled Nursing Facility *(in a Medicare-certified skilled nursing facility)*	• You pay for each benefit period (3), following at least a 3-day covered hospital stay: - Days 1 - 20: $0 for each day - Days 21 - 100: $114 for each day There is a limit of 100 days for each Benefit Period. (3)	You pay: • $25 each day for day(s) 1 - 100 • You are covered for 100 days each Benefit Period. • No prior Hospital stay is required.
6 - Home Health Care *(includes medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services, etc.)*	• There is no Copayment for all covered home health visits.	• There is no Copayment for Medicare-covered home health visits.
7 - Hospice	• You pay part of the cost for outpatient drugs and inpatient respite care. • You must receive care from a Medicare-certified hospice.	• There is no Copayment for Medicare-covered hospice. • You must receive care from a Medicare-certified hospice.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Inpatient Care *(continued)*		
8 – Transplants	• You pay $912 per confinement (up to 60 days). • You pay $228 per day (for days 61 – 90). • You pay $456 per each lifetime reserve day (maximum 60 lifetime reserve days).	• You pay $912 per confinement (up to 60 days). • You pay $228 per day (for days 61 – 90). • You pay $456 per each lifetime reserve day (maximum 60 lifetime reserve days). (The transplant copayment replaces the inpatient copayment for inpatient confinements)
Outpatient Care		
9 - Doctor Office Visits	• You pay 20% of Medicare-approved amounts. (1)(2) • If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. • This will not include laboratory tests. Please contact your physician for further details.	• You pay $10 for each primary care doctor office visit for Medicare-Covered Services. • You pay $25 for each Specialist visit for Medicare-Covered Services. *(See 33 - Routine Physical Exams for more information.)*
10 - Chiropractic Services	• You pay 20% of Medicare-approved amounts. (1)(2) • You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. • You pay 100% for routine care.	• You pay $25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
11 - Podiatry Services	• You pay 20% of Medicare-approved amounts. (1)(2) • You are covered for Medically Necessary foot care, including care for Medical Conditions affecting the lower limbs. • You pay 100% for routine care.	• You pay $25 for each Medicare-covered visit for Medically Necessary foot care.
12 - Outpatient Mental Health Care	• You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)	• For Medicare-covered Mental Health services, you pay $25 for each individual/group therapy visit.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Outpatient Care *(continued)*		
13 - Outpatient Substance Abuse Care	• You pay 20% of Medicare-approved amounts. (1)(2)	For Medicare-covered services, you pay $25 for each individual/group visit.
14 - Outpatient Services	• You pay 20% of Medicare-approved amounts for the doctor. (1)(2) • You pay 20% of outpatient facility charges. (1)(2)	You pay the following Copayment for Medicare-Covered Services: • $200 for each Medicare-covered visit or procedure to an ambulatory surgical center. • $200 for each Medicare-covered visit to an outpatient Hospital facility.
15 - Ambulance Services *(medically necessary ambulance services)*	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	• You pay $100 for Medicare-covered ambulance services; you do not pay this amount if you are admitted to the Hospital.
16 - Emergency Care *(You may go to any emergency room if you reasonably believe you need Emergency Care.)*	• You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the Hospital for the same condition within 3 days of the emergency room visit. (1)(2) • You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	• You pay $50 for each Medicare-covered emergency room visit; waived if you are admitted to the Hospital within 3 day(s). • Worldwide Coverage.
17 - Urgently Needed Care *(This is NOT Emergency Care)*	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	• You pay $40 for each Medicare-covered Urgently Needed Care visit; waived if you are admitted to the Hospital within 3 day(s). • Worldwide coverage.
18 - Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	You pay 20% of Medicare-approved amounts. (1)(2)	• You pay $25 for each Medicare-covered Occupational Therapy visit. • You pay $25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.
Outpatient Medical Services and Supplies		
19 - Durable Medical Equipment *(includes wheelchairs, oxygen, etc.)*	• You pay 20% of Medicare-approved amounts. (1)(2)	• You pay 10% of the cost for each Medicare-covered item.
20 - Prosthetic Devices *(includes braces, artificial limbs and eyes, etc.)*	• You pay 20% of Medicare-approved amounts. (1)(2)	• You pay 20% of the cost for each Medicare-covered item.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Outpatient Medical Services and Supplies *(continued)*		
21 - Diabetes Self-Monitoring Training and Supplies *(includes coverage for glucose monitors, test strips, lancets and self-management training.)*	• You pay 20% of Medicare-approved amounts. (1)(2)	• $0 Copayment for diabetes self-monitoring training. • 20% Copayment for diabetes supplies. • Injectable insulin – you pay $10 (Generic) or $30 (brand) for 30-day supply.
22 - Diagnostic Tests, X-Rays, and Lab Services	• You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) • There is no copayment for Medicare-approved lab services.	• $0 Copayment for a Medicare-covered X-ray visit. • $0 for each Medicare-covered clinical/ diagnostic lab service. • $25 for each Medicare-covered radiation therapy service. • $100 CT scan, MRI, Cardiac Nuclear Medicine. • $150 PET scan.
Preventive Services		
23 - Bone Mass Measurement *(for people with Medicare who are at risk.)*	• You pay 20% of Medicare-approved amounts. (1)(2)	• There is no Copayment for each Medicare-covered Bone Mass Measurement.
24 - Colorectal Screening Exams *(for people with Medicare age 50 and older.)*	• You pay 20% of Medicare-approved amounts. (1)(2)	• $0 Copayment for Members 50 years of age or older as follows: • $0 Copayment for sigmoidoscopy every four years • $0 Copayment for colonoscopy every ten years (not at high risk)
25 - Immunizations *(Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine.)*	• There is no Copayment for the pneumonia and flu vaccines. • You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) • You may only need the pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	• $0 Copayment for the Pneumonia and Flu vaccines. (No Referral necessary). • $0 Copayment for the Hepatitis B vaccine.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Preventive Services ***(continued)***		
26 - Mammograms (Annual Screening) *(for women with Medicare, age 40 and older)*	• You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings.	• $0 Copayment for Medicare-covered screening mammograms. (No Referral necessary).
27 - Pap Smears and Pelvic Exams *(for women with Medicare)*	• There is no Copayment for a pap smear once every 2 years, annually for beneficiaries at high risk. (2) • You pay 20% of Medicare-approved amounts for pelvic exams. (2)	• $0 Copayment for Medicare-covered Pap Smears or Pelvic Exams.
28 - Prostate Cancer Screening Exams *(for men with Medicare age 50 and older)*	• There is no Copayment for approved lab services and a Copayment of 20% of Medicare-approved amounts for other related services.(2)	• $0 Copayment for Medicare-covered Prostate Cancer screening exams.
Additional Benefits ***(What Original Medicare Does Not Cover)***		
29 - Outpatient Prescription Drugs	• You pay 100% for most prescription drugs.	• Retail Copayment per 30-day supply: - $10 Generic Drug - $30 Preferred Drug - $45 Non-Preferred Drug - $45 Out of area Drug • Mail Order Copayment per 90-day supply: - $20 Generic Drug - $60 Preferred Drug - $90 Non-Preferred Drug - $90 Out of Area • You must use designated retail pharmacies to get your prescriptions or the designated mail order services. • Certain classifications of drugs have quantity limits and/or subject to prior approval. Authorization may be required for prescription drugs. • Formulary may change on a quarterly basis, except in the event a medication poses a safety risk to the Member either in the discretion of Texas HealthSpring or the FDA. • $4,000 combined annual limit for retail and mail-order preferred and non-preferred brand name prescriptions.

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO
Additional Benefits ***(What Original Medicare Does Not Cover)***		
30 - Dental Services	• In general, you pay 100% for dental services.	• Value added discount program that provides a discount up to 70% for certain dental services at selected providers.
31 - Hearing Services	• You pay 100% for routine hearing exams and hearing aids. • You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	• You pay $25 for each Medicare-covered hearing exam (diagnostic hearing exams). • Value added discount program that provides a discount of up to 30% for hearing tests and hearing aid at selected providers.
32 - Vision Services	• You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2) • For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2) • You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2) • You pay 100% for routine eye exams and glasses.	• You pay $0 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). • You pay $25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye only).
33 - Routine Physical Exams	• You pay 100% for routine physical exams.	You pay $10 for each routine physical exam up to 1 exam every year.
34 - Transportation	• You pay 100%.	You pay $0 for each one-way trip up to 15 round trips to Plan approved locations every year.

(1) Each year you pay a total of $110 deductible

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A Benefit Period begins the day you go to a Hospital or Skilled Nursing Facility. The Benefit Period ends when you have not received Hospital or skilled nursing care for 60 days in a row. If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins. You must pay the inpatient Hospital Copayment for each Benefit Period. There is no limit to the number of Benefit Periods you can have.

(4) Lifetime reserve days can only be used once.

SECTION 2. Introduction, general information, service area, telephone and reference numbers

How to contact Texas HealthSpring Customer Service

If you have any questions or concerns, please call or write to Texas HealthSpring Customer Service. We will be happy to help you. Our business hours are Monday through Friday, 8:00 a.m. until 5:00 p.m. CT.

CALL 832-553-3480 locally, or 1-800-280-8888 toll free. These numbers are also on the cover of this booklet for easy reference.

TTY 1-877-893-1504 toll free. This number requires special telephone equipment. It is on the cover of this booklet for easy reference.

FAX 832-553-3419

WRITE PO Box 922002
Houston, TX 77292-2002

VISIT 2900 North Loop West – Suite 1300
Houston, TX 77092

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. The CMS contracts with and regulates Medicare Health Plans (including Texas HealthSpring) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

The Texas State Health Insurance Assistance Program – an organization in your state that provides free Medicare help and information

Texas State Health Insurance Assistance Program is a state organization paid by the Federal government to give free health insurance information and help to people with Medicare. Texas State Health Insurance Assistance Program can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Texas State Health Insurance Assistance Program has information about Medicare managed care plans and about Medigap (Medicare Supplement Insurance) Policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage Plan (like Texas HealthSpring Medicare HMO Plan) for the first time. (Medicare Advantage is the new name for Medicare + Choice). (Section 5 has more information about your Medigap guaranteed issue rights).

You can contact Texas State Health Insurance Assistance Program at 1-800-252-3439. You can also find the website for Texas State Health Insurance Assistance Program at www.medicare.gov on the web.

Texas Medical Foundation / Quality Improvement Organization – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Texas, the QIO is called Texas Medical Foundation. The doctors and other health experts in Texas Medical Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the Coverage for their Hospital stay is ending too soon. See Section 12 for more information about complaints.

You can contact Texas Medical Foundation at:
Barton Oaks Plaza II – Suite 200
901 Mopac
Austin, TX 78746
1-800-725-8315.

Other organizations (including Medicaid, Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare Premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact The Texas Medical Assistance Office at 1-800-252-8263. You may also contact Texas HealthSpring Customer Service at 832-553-3480 or toll free 1-800-280-8888, Monday through Friday, 8:00 am to 5:00 pm CT. TTY users should call 1-877-893-1504.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; Survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, Plan Premiums, or the open enrollment season.

What is the Plan?

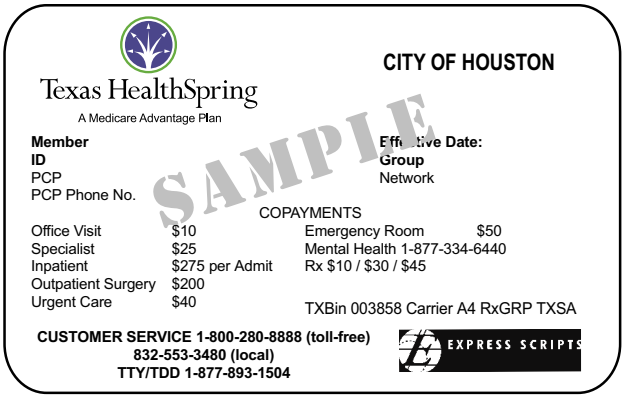
Now that you are enrolled in the Plan, you are getting your Medicare through Texas HealthSpring. The Plan is offered by Texas HealthSpring, and is an HMO for people with Medicare that meet the eligibility requirements set forth herein. The Medicare program pays us to manage health services for people with Medicare who are Members of the Plan. The Plan is **not** a Medicare Supplement Policy. See Section 3 for a definition of Medicare supplement policy. (Medicare supplement policies are sometimes called "Medigap" insurance policies.) Texas HealthSpring provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Plan gives you all of the usual Medicare services that are covered for everyone with Medicare. You also receive some additional benefits under the Texas HealthSpring Medicare HMO Plan, such as, prescription drug Coverage for Generic and brand name, routine vision and some others.

Since Plan is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, Hospitals, and other health providers that are part of Texas HealthSpring Provider Network. Since these doctors, Hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your Texas HealthSpring membership card instead of your red, white, and blue Medicare card.

Now that you are a Member of the Texas HealthSpring Plan, you have a Plan membership card. Here is a sample card to show what it looks like.



During the time you are a Plan Member and using Plan services, **you *must* use your Plan membership card instead of your red, white, and blue Medicare card to get Covered Services.** (See Section 7 for a definition and list of Covered Services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a Member. If you get covered services using your red, white, and blue Medicare card instead of your Plan membership card while you are a Plan Member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Plan membership card with you at all times. You will need to show this card when you get Covered Services. You will also need it to get your prescriptions at the pharmacy or through the contracted mail order company. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Help us keep your membership record up to date

Texas HealthSpring has a file of information about you as a Plan Member. Doctors, Hospitals, and other Plan Providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan Coverage the Primary Care Physician you chose when you enrolled, and other information. Section 2 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Customer Service and your employer know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance Coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. Call the number on the cover of this booklet to contact Customer Service.

What is the geographic Service Area for Plan?

The counties and parts of counties in our Service Area are: Brazoria, Chambers, Fort Bend, Galveston*, Hardin, Harris, Jefferson, Liberty, Montgomery, Orange, Polk, San Jacinto, Walker, and Waller.

*Galveston county includes: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592.

Using Plan Providers to get services covered by Plan

You will be using Plan Providers to get your Covered Services.

Now that you are a Member of Plan, with few exceptions, **you must use Plan Providers to get your Covered Services.**

- **What are "Plan Providers"?** "Providers" is the general term we use for doctors, other health care professionals, Hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "Plan Providers" when they participate in Texas HealthSpring Medicare Advantage Plan. When we say that Plan Providers "participate in Texas HealthSpring Medicare Advantage Plan," this means that we have arranged with them to coordinate or provide Covered Services to Members of Texas HealthSpring Medicare Advantage Plan.
- **What are "Covered Services"?** "Covered Services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Plan. Covered Services are listed in the Benefits Chart in Section 7.

As we explain below, you will have to choose one of our Plan Providers to be your PCP, which stands for **P**rimary **C**are **P**hysician. Your PCP will provide or arrange for most or all of your Covered Services. Care or services you get from Non-Plan Providers will not be covered, with few exceptions such as emergencies or with Prior Authorization arranged through your PCP. (When we say "Non-Plan Providers", we mean providers that are not part of Texas HealthSpring provider network.)

The Provider Directory gives you a list of Plan Providers

Every year as long as you are a Member of Plan, we will send you a Provider Directory, which gives you a list of Plan Providers. If you don't have the Provider Directory, you can get a copy from Customer Service (call the number on the cover of this booklet). You can also view the current list of Plan Providers on our website at www.texashealthspring.com. You can ask Customer Service for more information about Plan Providers, including their qualifications and experience. Customer Service can give you the most up-to-date information about changes in Plan Providers and about which ones are accepting new patients.

Access to care and information from Plan Providers

You have the right to get Timely Access to Plan Providers and to all services covered by the Plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 2 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Provider)

What is a "PCP"?

When you become a Member of Plan, you must choose a Plan Provider to be your PCP. Your PCP is a physician who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the Covered Services you get as a Plan Member. For example, in order to see a Specialist, you usually need to get your PCP's approval first. This is called getting a "Referral" to a Specialist.

How do you choose a PCP?

If there is a particular Plan Specialist or Hospital that you want to use, check first to be sure your PCP makes Referrals to that Specialist, or uses that Hospital. The name and office telephone number of your PCP is printed on your membership card.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 7, there are only a few types of Covered Services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the Covered Services you get as a Plan Member. This includes your x-rays, laboratory tests, therapies, care from doctors who are Specialists, Hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other Plan Providers about your care and how it is going. If you need certain types of Covered Services or supplies, your PCP must give approval in advance (such as giving you a Referral to see a Specialist). In some cases, your PCP will also need to get Prior Authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 2 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a Medical Emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, Hospital, or Urgent Care Center. Section 7 tells what to do if you have a Medical Emergency or urgent need for care.

What to do if it is not a Medical Emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is ***not*** a Medical Emergency, call the PCP's phone number on your ID card. There will always be a doctor on call to help you.

See Section 7 for more information about what to do if you have an urgent need for care.

Getting care from Specialists

When your PCP thinks that you need specialized treatment, he or she will give you a Referral (approval in advance) to see a Plan Specialist. A Specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of Referrals to Plan Specialists, your PCP may need to get approval in advance from Texas HealthSpring's Health Services Department. This is called getting " Prior Authorization".

It is very important to get a Referral from your PCP before you see a Plan Specialist (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a Referral before you receive services from a Specialist, you may have to pay for these services yourself.** If the Specialist wants you to come back for more care, check first to be sure that the Referral you got from your PCP covers more visits to the Specialist.

If there are specific Specialists you want to use, find out whether your PCP sends patients to these Specialists. Each Plan PCP has certain Plan Specialists they use for Referrals. This means that **the Plan Specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a Plan Specialist that your current PCP cannot refer you to. Later in this section, under "Choosing your PCP," we tell you how to change your PCP. If there are specific Hospitals you want to use, find out whether your PCP uses these Hospitals.

There are some services you can get on your own, without a Referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a Plan Member. If you get services from any doctor, Hospital, or other health care provider without getting a Referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a Plan Provider. ***But there are a few exceptions:*** you can get the following services on your own, without a Referral or approval in advance from your PCP; this is called **"self-referral"** when you get these services on your own. You still have to pay your Copayment for these services.

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a Referral from your PCP ***only*** if you get it from a Plan Provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a Plan Provider).
- Emergency services, whether you get these services from Plan Providers or non-Plan Providers (see Section 7 for more information).
- Urgently needed care that you get from Non-Plan Providers when you are temporarily outside the Plan's Service Area. Also, Urgently Needed Care that you get from Non-Plan Providers when you are in the Service Area but, because of unusual or extraordinary circumstances, the Plan Providers are temporarily unavailable or inaccessible. (See Section 7 for more information about Urgently Needed Care. Earlier in this section, we explain the Plan's Service Area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the Plan's Service Area, if possible, please let us know before you leave the Service Area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the Service Area.

Getting care when you travel or are away from the Plan's Service Area

If you need care when you are outside the Service Area, your Coverage is limited. The only services we cover when you are outside our Service Area are care for a Medical Emergency, Urgently Needed Care, renal dialysis, and care that Texas HealthSpring or a Plan Provider has approved in advance. See Section 7 for more information about care for a Medical Emergency and Urgently Needed Care. If you have questions about what medical care is covered when you travel, please call Customer Service at the telephone number on the cover of this booklet.

How to change your PCP

You may change your PCP for any reason, at any time. PCP changes are effective the first of the following month. To change your PCP, call Customer Service at the number on the cover of this booklet. When you call, be sure to tell Customer Service if you are seeing Specialists or getting other Covered Services that needed your PCP's approval (such as home health services and Durable Medical Equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor leaves the Plan?

Sometimes a PCP, Specialist, clinic, or other Plan Provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of Plan. If your PCP leaves Plan, we will let you know, and help you switch to another PCP so that you can keep getting Covered Services. In most cases, we will provide at least 30 days notice before a PCP leaves the Plan.

Your rights and responsibilities as a Member of Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of this section we explain your Medicare rights and protections as a Member of Plan. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Texas HealthSpring must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Customer Service at the number on the cover of this booklet. Customer Service can also help if you need to file a complaint about access (such as wheel chair access).

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this Plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask Plan Providers to make additions or corrections to your medical records (if you ask Plan Providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number on the cover of this booklet.

Your right to see Plan Providers and get Covered Services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from Plan Providers, that is, from doctors and other health providers who are part of Plan. You have the right to choose a Plan Provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health Specialist (such as a gynecologist) without a Referral. You have the right to Timely Access to your providers and to see Specialists when care from a Specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use Plan Providers to get the care and services you need. Section 7 explains your rights to get care for a Medical Emergency and Urgently Needed Care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Plan. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing Experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a Plan Provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 12.

You have the right to refuse treatment. This includes the right to leave a Hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family Member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as the Texas State Health Insurance Assistance Program, your SHIP (which stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram). Section 2 of this booklet tells how to contact the Texas State Health Insurance Assistance Program. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family Members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the Hospital. If you are admitted to the Hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have ***not*** signed an advance directive form, the Hospital has forms available and will ask if you want to sign one.

Remember, it is ***your choice*** whether you want to fill out an advance directive (including whether you want to sign one if you are in the Hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you ***have*** signed an advance directive, and you believe that a doctor or Hospital has not followed the instructions in it, you may file a complaint with the Texas State Health Insurance Assistance Program at 800-252-3439. You can also find the website for the Texas State Health Insurance Assistance Program at www.medicare.gov on the internet.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your Coverage or care. "Appeals" and "Grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and Grievances are discussed in Section 12, If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the Appeals and Grievances that Members have filed against Texas HealthSpring in the past. To get this information, call Customer Service at the phone number on the cover of this booklet.

Your right to get information about your health care Coverage and costs

This booklet and the Summary of Benefits tells you what medical services are covered for you as a Plan Member and what you have to pay. If you need more information, please call Customer Service at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may

get for services not covered by Plan. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an Appeal to ask us to change this decision. See Section 12 for more information about filing an Appeal.

Your right to get information about Texas HealthSpring, the Plan, and Plan Providers

You have the right to get information from us about Texas HealthSpring and Plan. This includes information about our financial condition, about our health care providers and their qualifications, and about how Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Service at the phone number on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number on the cover of this booklet. You can also get free help and information from the Texas **S**tate **H**ealth **I**nsurance Assistance **P**rogram, or SHIP. (Section 2 tells how to contact the Texas State Insurance Assistance Program). In addition, the Medicare program has written a booklet called Your Medicare Rights and Protections. To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 800-368-1019; TTY users should call 1-800-537-7697.
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Service at the number on the cover of this booklet. You can also get help from the Texas State Health Insurance Assistance Program, or SHIP (Section 2 tells how to contact the Texas State Health Insurance Assistance Program).

What are your responsibilities as a Member of the Plan?

Along with the rights you have as a Member of Plan, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your Coverage and the rules you must follow to get care as a Member. You can use this booklet and other information we give you to learn about your Coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number on the cover of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.

- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, Hospitals, and other offices.
- To pay your Plan Premiums and any Copayments you may owe for the Covered Services you get. You must also meet your other financial responsibilities that are described in Section 6 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number on the cover of this booklet.

SECTION 3. Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Agreement – means the Group Application, including the Evidence of Coverage, Summary of Benefits, any supplemental benefits, exhibits, Amendments, endorsements, and inserts or attachments herein.

Alternative Health Benefits Plan – any health benefit plan, other than this Plan, that is offered by the Group.

Amendment - an attached description of additional or alternative provisions of this EOC. Amendments are effective only when signed by Texas HealthSpring and approved by CMS and, where applicable, the State of Texas. Amendments are subject to all conditions, limitations, and exclusions of this EOC except for those that are specifically amended.

Appeal – Section 12 explains about Appeals, including the process involved in making an Appeal.

Application - the forms prescribed by HMO that each Subscriber shall, on his or her own behalf and on behalf of his or her Dependents, be required to complete and submit to HMO for the purpose of enrolling for Coverage in the Plan.

Benefit Period – a Benefit Period begins the day you go to the Hospital or Skilled Nursing Facility. The Benefit Period ends when you have not received Hospital or skilled nursing care for 60 days in a row. If you go into the Hospital after one Benefit Period has ended, a new Benefit Period begins. You must pay the inpatient Hospital Copayment for each Benefit Period. There is no limit to the number of Benefit Periods you can have.

Centers for Medicare & Medicaid Services (CMS) - the Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 2 tells how you can contact CMS.

Child – means (1) the Subscriber's unmarried natural Child, foster Child, stepchild, legally adopted child or Grandchild; (2) a Child whose adoption by the Subscriber is anticipated and for whom the Subscriber has legal support obligations; (3) a Child under the Subscriber's legal guardianship; or (4) in the instance of a divorced Subscriber, a Child for whom the Subscriber has been ordered to assume medical responsibility in a divorce decree entered by a court of competent jurisdiction. Except in the instance of item (4), the person must reside with the Subscriber in order to be a "Child." Child excluded a person who is on active military duty for any country.

Coinsurance – is a payment you make for your share of the cost of certain Covered Services you receive. Coinsurance is **a *percentage* of the cost of the service** (such as paying 20 % for Durable Medical Equipment). You pay your Coinsurance when you get the service. The Benefits Chart in Section 7 gives your Coinsurance for Covered Services.

Copayment – is a payment you make for your share of the cost of certain Covered Services you receive. A Copayment is **a set amount per service** (such as paying $10 for a PCP visit). You pay it when you get the service. The Benefits Chart in Section 7 gives your Copayments for Covered Services. Section 8 gives your Copayments for prescription drugs.

Coverage – entitlement to payment of Covered Services available under the EOC, subject to the terms, conditions, limitations and exclusions of the EOC.

Covered Services – the general term we use in this booklet to mean all of the health care services and supplies that are covered by Plan. Covered Services are listed in the Benefits Chart in Section 7.

Custodial Care - domiciliary care, respite care or rest cures, or private duty nursing, or other non-health services, such as assistance in activities of daily living or health, related services which do not seek to cure or which are provided during periods when the Medical Condition of the patient is not changing, or which do not require continued administration by trained medical personnel. Custodial Care is not covered under Plan nor covered by Medicare unless in conjunction with Skilled Care Services and/or services provided at an Inpatient Rehabilitation Facility.

Customer Service - a department within Texas HealthSpring responsible for answering your questions about your membership, benefits, Grievances, and Appeals. See Section 2 for information about how to contact Customer Service.

Deferred Retired Employee - means an individual who meets the Subscriber eligibility requirements set forth in Section 4 of this Agreement, who was an employee of the Group and as a member of one of the State statutory pension plans that is offered to the Group's employees:

A. Has completed sufficient service time and/or met any other applicable requirements to be eligible to receive a deferred pension under the terms of the pension Plan; and

B. Will attain the age necessary to commence actually receiving benefit payments under the pension Plan on or before the fifth anniversary of the employee's severance from active service with the Group.

Dentist - a doctor of dental surgery (D.D.S.) or doctor of medical Dentistry (D.M.D.) who is duly licensed and qualified to provide dental surgery, treatment or care under the law of the jurisdiction in which treatment is received.

Dependent - means an Eligible Dependent who has been enrolled in the Plan, for whom the Premium payments required hereunder have been received by HMO in accordance with the terms of this Agreement and who continues to meet the eligibility requirements set forth in this EOC.

Designated Transplant Facility - a Hospital, named as such by Texas HealthSpring and certified by Medicare, which has entered into an agreement with or on behalf of Texas HealthSpring to provide medically appropriate health services for transplants that are Covered Services. A Designated Transplant Facility may/or may not be located within the Service Area.

Disenroll or Disenrollment - the process of ending your membership in Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 5 tells about Disenrollment.

Durable Medical Equipment - equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of Durable Medical Equipment include wheelchairs, Hospital beds, or equipment that supplies a person with oxygen.

Effective Date - means January 1, 2005.

Eligible Dependent - means an Eligible Employee's spouse or Child who meets the Dependent eligibility requirements set forth in this Agreement.

Eligible Employee - means an individual who meets the Subscriber eligibility requirements set forth in this Agreement.

Eligible Expenses - fees for Covered Services that are either: (a) for contracted providers, the contracted charge or if none, the lesser of the Medicare Allowable Charge or the provider's billed charges; or (b) for non-contracted providers, (i) the lesser of the Medicare Allowable Charge or the provider's billed charges for emergency health services, post-stabilization care, out-of-area renal dialysis services, and urgently needed health services, or (ii) the Medicare Allowable Charge for Covered Services provided through a Referral. All Eligible Expenses must be Covered Services under this EOC and incurred while this EOC is in effect.

Emergency Care - Covered Services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency Medical Condition. Section 7 tells about emergency services.

Evidence of Coverage ("EOC") and Disclosure Information - this document, along with your enrollment form, which explains the Covered Services, defines our obligations, and explains your rights and responsibilities as a Member of the Plan.

Experimental, Investigational or Unproven Procedures - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices not covered under Medicare (following CMS guidelines via the Medicare Carriers Manual and Coverage Issues Manual) that are determined by the Plan (at the time it makes a determination regarding Coverage in a particular case) to be:

A. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopoeia Dispensing Information or the American Medical Association Drug Evaluations as appropriate for the proposed use; or
B. subject to review and approval by any institutional review board for the proposed use; or
C. a service that does not meet the definition of a Covered Service.

If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment), the Plan may determine that an Experimental service meets the definition of a Covered Service for that sickness or condition. For this to occur, Plan must determine that the procedure or treatment is promising, but unproven, and the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

However, nothing contained in this EOC shall require Plan to approve and/or pay for any Experimental Procedures unless Plan approves the Experimental, procedure(s) in writing in advance of such Experimental Procedure(s) being performed.

Extended Benefits - means the extension of certain benefits, under specific conditions, beyond the termination date of a Member's participation in that Plan or the termination of the Plan.

Formulary – a list of outpatient prescription drugs covered by Plan.

Generic - a prescription drug product that is manufactured and distributed by several pharmaceutical manufacturers that is: (a) chemically equivalent to a Brand-name drug for which a patent has expired; and (b) identified as a Generic product by Plan or Plan's designee. A prescription drug product is classified as a Generic based on available data resources, such as first data bank; therefore, a product identified as Generic by the manufacturer or pharmacy may not be classified as Generic by Plan.

Grandchild – means a natural or adopted Grandchild of the Subscriber who is Primarily Dependent on the Subscriber. The Subscriber will be required to document to the satisfaction of the Group that the Grandchild is Primarily Dependent on the Subscriber.

Grievance – Section 12 explains about Grievances.

Group – means the City of Houston.

Home Health Agency – a Medicare-certified entity that: (a) is engaged in providing Home Health Agency care services; and (b) is licensed, certified, or otherwise authorized as permitted under the law of the jurisdiction in which treatment is received.

Hospital - a Medicare-certified institution, operated as permitted under law, that: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick

individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of physicians; and (b) has 24-hour nursing services. A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - physiological damage other than sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Medicare-certified institution that is a Hospital or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility, which provides rehabilitation Covered Services (physical therapy, occupational therapy, speech therapy, and/or cardiac rehabilitation) on an inpatient basis as permitted under the law of the jurisdiction in which treatment is received.

Medical Condition – any physical or mental condition, including, without limitation a condition that results from illness, Injury (accidental or non-accidental), pregnancy or congenital malformation.

Medical Emergency – is when you reasonably believe that your health is in serious danger -- when every second counts. A Medical Emergency includes severe pain, a bad Injury, a serious illness, or a Medical Condition that is quickly getting much worse.

Medically Necessary – services or supplies that: are proper and needed for the diagnosis or treatment of your Medical Condition; are used for the diagnosis, direct care, and treatment of your Medical Condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare - the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization - a public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Texas HealthSpring is a Medicare Advantage Organization.

Medicare Advantage Plan - a benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform Premium and uniform level of cost-sharing to all people with Medicare who live in the Service Area covered by the Plan. A Medicare Advantage Organization may offer more than one Plan in the same Service Area. Texas HealthSpring Medicare HMO Plan is a Medicare Advantage Plan.

Medicare Allowable Charge – is the maximum amount paid by Medicare for services to Medicare beneficiaries.

Medicare Appeals Process – the process to address any complaints or concerns that involve the denial of Covered Services or reimbursement of a claim (see Section 12).

Medicare Cost Plan – a specific set of health benefits offered at a uniform Premium and uniform level of cost-sharing to all people with Medicare living in the Service Area covered by the Plan. A company offering a Cost Plan may offer more than one Plan in the same Service Area. Members under this Plan may use Original Medicare benefits from any Medicare provider.

Medicare Fee-for-Service – a payment system by which physicians, Hospitals and other providers are paid for each service performed (also known as original Medicare).

Medicare Part A - Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and hospice care (hospice care is only covered through Original Medicare).

Medicare Part B - supplementary medical insurance that covers physician services (in both Hospital and non-Hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include, but not limited to, lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anticancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medigap (Medicare Supplement Insurance) Policy – many people who get their Medicare through Original Medicare buy "Medigap" or Medicare Supplement Insurance policies to fill "gaps" in Original Medicare Coverage.

Member (Member of Plan, or "Plan Member") – a person with Medicare who is eligible to get Covered Services, who has enrolled in Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Mental Health Services – Covered Services under this EOC for the diagnosis and treatment of Mental Illnesses covered under Medicare. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service. Only Mental Health Services covered under Medicare are Covered Services under this EOC.

Mental Health/Substance Abuse Designee - the organization, entity, or individual that provides or arranges the Mental Health Services and Substance Abuse Services covered under this EOC.

Mental Illness - those mental health or psychiatric conditions described in the current Diagnostic and Statistical Manual of the American Psychiatric Association that are covered by Medicare.

Non-Plan Provider or Non-Plan Facility - a provider or facility that we have not arranged with to coordinate or provide Covered Services to Members of Plan. Non-Plan Providers are providers that are not employed, owned, or operated by Texas HealthSpring and are not under contract to deliver Covered Services to you. As explained in this booklet, most services you get from non-Plan Providers are not covered by Texas HealthSpring or Original Medicare.

Original Medicare - a Plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "Fee-for-Service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, Hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital insurance) and Part B (medical insurance).

Out-of-Pocket Maximum – this is the maximum annual out-of-pocket cost you pay for Copayments and Coinsurance for specified services. **Once the Out-of-Pocket Maximum has been met, you no longer pay Copayments or Coinsurance for certain Plan services. Physician services do NOT apply to the Out-of-Pocket Maximum.**

Placement for Adoption or Placed for Adoption – means the assumption and retention of a legal support obligation of an unmarried Child by an Eligible Employee or a Subscriber with whom the Child had been placed in anticipation of such person's adoption of the Child. The Child's Placement for Adoption with such person terminates upon the termination of such person's legal support obligation.

Plan – is the term we use throughout the EOC to refer to the Texas HealthSpring Medicare HMO Plan which is defined in this section.

Plan Provider – **"Provider"** is the general term we use for doctors, other health care professionals, Hospitals, and other health care facilities that are licensed or certified by Medicare and by the State of

Texas to provide health care services. We call them **"Plan Providers"** when they are part of Plan. When we say that Plan Providers are "part of Plan," this means that we have arranged with them to coordinate or provide Covered Services to Members of Plan. Texas HealthSpring pays Plan Providers based on the contracts it has with the providers.

Premium - the periodic fee required from you and paid to Plan in accordance with the terms of this EOC, which, along with your Part A and/or Part B Premium paid to Medicare, entitles you to Coverage under this EOC.

Primary Care Physician (PCP) - a health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing Covered Services while you are a Plan Member. Section 2 tells more about PCPs.

Primarily Dependent - means receiving more than fifty percent (50%) of his or her support from the Subscriber, meeting the requirements to be claimed as a Dependent on the Subscriber's federal income tax return and being a Dependent Child.

Prior Authorization - approval in advance to get services. Some services are covered only if your doctor or other Plan Provider gets "Prior Authorization" from Texas HealthSpring. Covered Services that need Prior Authorization are marked in the Benefits Chart.

Quality Improvement Organization (QIO) - groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient Hospitals, Hospital outpatient departments, Hospital emergency rooms, Skilled Nursing Facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 2 for information about how to contact the QIO in your state and Section 12 for information about making complaints to the QIO.

Reconstructive Surgery – surgery which is incidental to an Injury, sickness or congenital anomaly when the primary purpose is to restore or improve normal physiological functioning of the involved part of the body. (A congenital anomaly is a physical developmental defect that is present at birth and is identified within the first twelve months of birth.) The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as a cosmetic procedure when a physical impairment exists, and the surgery restores or improves normal physiological function. The fact that a person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, sickness or congenital anomaly does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Referral - your PCP's approval for you to see a certain Specialist or to receive certain Covered Services.

Rehabilitation Services – these services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a Plan Provider. See Section 7 for more information.

Retiree - means an individual who meets the Subscriber eligibility requirements set forth in this Agreement, who has retired from the service of the Group and is receiving retirement benefit payments under one of the several pension plans offered by the Group, provided that, between the time when such person assumed Retiree status and when such person first seeks to enroll in the Plan, such person and his or her Dependents were continuously enrolled in the Plan or an Alternative Health Benefits Plan. Notwithstanding the foregoing, new Dependents, who meet the eligibility criteria of the Plan, of such Retiree, acquired after such Retiree enrolled as a Subscriber in the Plan, shall be permitted to enroll in accordance with this Agreement.

Service Area - Section 2 tells about Plan's Service Area. "Service Area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular Plan offered by a Medicare Health Plan.

Skilled Care Services - Skilled Nursing or Rehabilitation Services that meet all of the following criteria:

A. must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;

B. are ordered by a physician; and

C. are necessary for the treatment of the sickness, Injury or pregnancy.

A determination of benefits for Skilled Care Services is based on both the skilled nature of the service and the need for physician-directed medical management. Skilled Care Services are not determined by the availability of caregivers to perform them; the absence of an available caregiver does not cause the service to become "skilled."

Skilled Nursing Facility - a Medicare certified nursing facility that: (a) provides Skilled Care Services; and (b) is licensed and operated as permitted under the law of the jurisdiction in which treatment is received.

Specialist – a contracted physician who provides certain specialty medical care not generally provided by a Primary Care Physician and that your Primary Care Physician may refer you to for specialized care. Unless otherwise determined by Plan, a Specialist generally shall not include physicians in family practice, general practice, internal medicine, or pediatrics.

Subscriber - means an Eligible Employee or Retiree who has enrolled in the Plan and for whom the Premium payments required under this Agreement have been received by HMO in accordance with the terms of this Agreement.

Substance Abuse Services – Covered Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that are covered by Medicare. The fact that a disorder is listed in the DSM does not mean that treatment of the disorder is a Covered Service.

Survivor – means a Dependent whose Coverage is continued, in the event of termination of a Subscriber's Coverage due to the death of the Subscriber, following the date of the Subscriber's death, provided that the Subscriber's surviving spouse or, in the absence of such a surviving spouse, the Subscriber's eldest Dependent shall be deemed to be the Subscriber for purposes of the Plan, and further provided that the Premiums required with respect to all such Dependents of the deceased Subscriber are paid.

Texas HealthSpring Medicare HMO Plan – the Plan that You are enrolling in under your City of Houston benefits that is offered by Texas HealthSpring I, LLC to all City of Houston Medicare eligibles.

Timely Access – means that you can get appointments and services within a reasonable amount of time.

Urgent Care Center – a health center, other than a Hospital emergency room which provides short-term medical care for sickness, Injury, or pregnancy requiring immediate attention. Urgent Care Centers generally are freestanding facilities but may be a specially designated part of a Hospital's Emergency Care system.

Urgently Needed Care – is when you need medical attention right away for an unforeseen illness or Injury, and it is not reasonable given the situation for you to get medical care from your PCP or other Plan Providers. In these cases, your health is not in serious danger. As we explain below, how you get "Urgently Needed Care" depends on whether you need it when you are in the Plan's Service Area, or outside the Plan's Service Area. Section 2 tells about the Plan's Service Area.

SECTION 4. Eligibility, Enrollment and Effective Date

Eligibility

SECTION 4.1 ELIGIBILITY.

In order to be eligible for Coverage, you must meet all applicable requirements of Sections A and B as set forth below:

A. Medicare and Plan Requirements

1. Fully and accurately complete and sign the Application documents provided by Plan.
2. Be enrolled in Medicare Parts A and B. Only persons with both Medicare Parts A and B are allowed to be enrolled in Plan. Therefore, if you are not currently entitled to Medicare Part A, you must purchase Coverage for Part A services through the Social Security Administration and pay the Part A Premium to Medicare. You are responsible for paying the appropriate Premiums for Medicare Part A and/or Part B. If you are not eligible for Medicare Parts A and B or if you fail to pay the appropriate Premiums for Medicare Parts A and/or B, then you are not eligible to participate with Plan.
3. Reside permanently within the Service Area. (If you reside temporarily outside the Service Area for more than six (6) consecutive months, you are deemed a permanent resident elsewhere and are no longer eligible for Coverage and will be Disenrolled by Plan).
4. Not have end stage renal disease (ESRD) at the time of application unless, eligible to enroll under a special election period due to the discontinuation of another Medicare Advantage Plan in your area. Please note, an individual who receives a transplant that restores kidney function and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of eligibility.

   You may not be able to enroll for Coverage if you have end stage renal disease (ESRD). However, if you develop ESRD while you are covered under the EOC, you cannot be forced to Disenroll from Plan solely due to developing ESRD.
5. Agree, once fully informed, to abide by Plan rules and responsibilities (see Member materials) and you must notify Plan of any changes in status that affect his or her ability to meet the eligibility criteria set forth in the EOC.

B. Group Eligibility Requirements & Enrollment Effective Dates

1. To be eligible to enroll as a Subscriber in the Plan, a person must reside in the Service Area, not be eligible for Coverage and/or covered under Extended Benefits (or Coverage similar thereto) of any health benefit plan, be eligible for Medicare Parts A&B and be:
   a. Within one of the following categories:
      (i) a Deferred Retired Employee;
      (ii) a Retiree; or
      (iii) a Survivor; and
   b. On the Effective Date of this EOC, You are enrolled in one of the Alternate Health Benefit Plans offered by the Group.
2. To be eligible to enroll as a Dependent, a person must not be eligible for Coverage and/or covered under Extended Benefits (or Coverage similar thereto) of any other health plan and be:
   a. The spouse of a Subscriber; or a former spouse entitled to support from the Subscriber under

a court order when a request for enrollment has been made within thirty-one (31) days after issuance of the court order; or

b. A Child of any age who is Medicare eligible based upon disability or other qualifying criteria and meets the eligibility criteria set forth below and if you were receiving benefits under an Alternative Health Benefits Plan offered by the employer prior to the Effective Date, except that a Child over age 25 must be incapable of self-sustaining employment because of mental retardation or physical handicap, provided:

(i) such Child was an enrolled Dependent prior to attainment of the limiting age;

(ii) was disabled before the limiting age; and

(iii) Subscriber furnishes Plan proof of such incapacity, dependency and eligibility for Medicare from time to tie as Plan deems appropriate.

3. Notwithstanding the foregoing, an Eligible Employee may elect to be covered only as a Subscriber or a Dependent, but not both simultaneously. If and when a person terminates Coverage under the Plan as either a Subscriber or Dependent, such person shall have the right to continue Coverage under either definition that continues to apply, if any.

4. A person who is on active military duty or a spouse who is legally separated from the Subscriber shall not be eligible to enroll in the Plan.

5. Coverage of Survivors shall be limited to Dependents who were covered at the time of the Subscriber's death, except that Coverage may also be extended to any newborn Child of the deceased Subscriber in accordance with the provisions of this Agreement that pertain to newborn children that may be Medicare eligible.

6. An Eligible Dependent may only become a Dependent under the Plan in one of the following ways:

a. At Same Time Eligible Employee or Retiree Becomes Covered. An Eligible Dependent included as a separate Application with an Eligible Employee or Retiree who is seeking to enroll as a Subscriber shall become covered as a Dependent at the same time the Eligible Employee or Retiree becomes covered as a Subscriber. Both shall have the same Member Effective Date.

b. Newly Acquired Dependents Who First Become Eligible After Subscriber enrolls.

(i) New Spouses and Stepchildren. A Subscriber's newly acquired spouse who meets the requirements to be an Eligible Dependent, on whose behalf Subscriber submits a completed Application to HMO within thirty-one (31) days of the marriage, shall become covered as of the first day of the month following receipt of the completed Application. If, as a result of the marriage, the Subscriber acquires a stepchild who meets the requirements to be an Eligible Dependent, and that stepchild is included on a separate Application with the new spouse and any required Premium is paid, the stepchild shall also become covered as of the first day of the month following receipt of the completed Application.

(ii) Newborn Children. A Subscriber may enroll a Child who satisfies the requirements to be an Eligible Dependent by submitting a completed Application to HMO, prior to the end of the thirty-one (31) day period beginning on the date of birth. The Member Effective Date of such a Child shall be the first of the month following receipt of the Application.

(iii) Foster and Adoptive Children. A Subscriber's Child who is a foster or adoptive Child who satisfies the requirements to be an Eligible Dependent is eligible for Coverage on the same basis as a newborn Child, except that the Member Effective Date shall be the first of the month following receipt of the Application.

(iv) Court-ordered Coverage. Dependent children that meet the requirements of an Eligible Dependent and for whom the Subscriber has received a court order requiring the Subscriber to provide health Coverage will be covered if the Subscriber submits to HMO an Application within thirty-one (31) days of the date of receipt of the court order by Group. Coverage for court ordered Dependents will be effective the first of the month following receipt of the Application.

Coverage for a Dependent spouse for whom the Subscriber has received a court order requiring the Subscriber to provide health Coverage will be effective the first of the month following receipt of the Application.

SECTION 4.2 ENROLLMENT.

Under this EOC an Eligible Employee or Retiree may apply for enrollment in the Plan by submitting a completed Application. Plan must receive approval of your enrollment Application from CMS.

If you meet the above conditions, you cannot be denied Coverage under this EOC on the basis of your health. Plan will not deny, limit or condition Coverage to you on the basis of Medical Condition, including mental as well as physical illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Eligible persons may enroll in Plan by completing the Application provided by Plan or your employer. When the enrollment has been confirmed by CMS, you will be notified by Plan of the Effective Date of Coverage.

Enrollment in Plan is effective in accordance with any applicable CMS guidelines. If for any reason an Application is rejected by CMS, Plan will contact you for additional information or provide instructions to follow regarding resubmission of your Application.

SECTION 4.3 EFFECTIVE DATE.

Your Effective Date of enrollment will generally be the first day of the month following the date your signed, completed Application is received by Plan.

Your actual Effective Date of enrollment in Plan is the date indicated on the letter Plan will send to you to confirm your enrollment in Plan. From that date forward, you must receive all Covered Services in accordance with Plan's Coverage Rules. In no event is there Coverage before the Effective Date and you will be responsible for all costs of medical services prior to the Effective Date.

In the event an employee or Dependent has satisfied the eligibility conditions in this Agreement on the date that Coverage under this Agreement becomes effective, such person shall, as of that date, be covered under this Agreement. HMO, however, shall not be required to cover, arrange for, or otherwise be liable for services rendered prior to the Effective Date or for such confinement or services not covered under this Agreement, including those services covered under Extended Benefits Coverage of any other health Plan.

If for any reason an Application is rejected by CMS, Plan will contact you for additional information or provide instructions to follow regarding resubmission of your Application.

Important Note Concerning Medicare Supplement (Medigap) Policy

If you currently have a Medicare Supplement (Medigap) Policy, you should consider canceling it once you receive written confirmation of your enrollment in Plan. However, each individual's situation is different and you should assess whether or not to cancel your Medigap policy. Before you make a decision, please note the following.

- If you retain a Medigap policy, you may not be reimbursed for health care services you receive from non-contracted providers. Most Medigap policies will not pay for any portion of such services because Medigap insurers process their claims based on proof of a Medicare Fee-for-Service payment (a payment system by which physicians, Hospitals and other providers are paid for each service performed), usually in the form of a Medicare Summary Notice. However, as long as you are a Member of Plan, Medicare Fee-for-Service will not be processing any claims for medical services you receive. Plan has the financial responsibility for all Medicare-covered health care services you need as long as you follow Plan's rules on how to receive Covered Services.
- If you terminate your Medigap policy and then later Disenroll from Plan, you may not be able to have your Medigap policy reinstated because the Medigap insurer may be entitled to refuse to sell you a policy or place limits on the policy based on your health status. In certain cases, you will be entitled to purchase a specific Medigap policy without regard to your health status. In particular:
  - If you are Disenrolled from Plan for a reason that does not involve any wrongdoing on your part (e.g. you move outside the Service Area), you are entitled to purchase any Medigap Plan A, B, C or F sold in your state.
  - If this is the first time you have enrolled in a Medicare Advantage Plan, and you voluntarily Disenroll within twelve consecutive months from your Effective Date, you are entitled to purchase the same Medigap policy you had before enrollment in Plan if it is still available from the same insurer. If it is not available, you are entitled to purchase any Medigap policy A, B, C or F sold in your state.
  - If you enrolled in Plan when you first became eligible for Medicare and then Disenroll within twelve consecutive months from your Effective Date, you are entitled to purchase any Medigap policy sold in your state.

In any of the above situations, you must apply for Medigap Coverage and submit evidence of the date of your loss of Coverage within 63 days after you Disenroll from Plan. You may apply for a Medigap policy prior to your Disenrollment date with Plan in order for that policy to take effect as soon as you return to Original Medicare. Please call Customer Service for details or more information.

What happens if you join or drop out of Plan during a SNF or Hospital stay?

If you either join or leave Plan during a SNF or Hospital stay, special rules apply to your Coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Service at 832-553-3480 locally, or 1-800-280-8888 toll free. They can explain how your services are covered for this stay, and what you owe to Plan, if any, for the periods of your stay when you were and were not a Plan Member.

SECTION 5. Disenrollment - Leaving Plan and your choices after you leave.

What is "Disenrollment"?

"Disenrollment" from Plan means **ending your membership** in Plan. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Plan because you have decided that you want to leave. You can do this for any reason.
- There are also a few situations where you would be required to leave. For example, you would have to leave Plan if you move out of Plan's geographic Service Area or if Plan leaves the Medicare program. Plan is not allowed to ask you to leave the Plan because of your health.

Whether leaving the Plan is your choice or not, this section explains your Medicare Coverage choices after you leave and the rules that apply.

What are your choices if you leave the Plan?

Your options if you leave Plan include, but are not limited to, the following:

- Enrolling in another Medicare Advantage Plan offered by your employer.
- Enrolling in another Alternative Health Benefits Plan (such as a HMO / PPO).
- Discontinue receiving health benefits from your employer and returning to Original Medicare.

How to change from the Plan to another Alternative Health Benefits Plan.

If you want to change from Plan to another Alternative Health Benefits Plan that is not a Medicare Advantage Plan, here is what to do:

1. Contact your employer's benefits administrator.
2. If your Alternative Health Benefits Plan is accepting new Members, apply for membership in the plan. You need to tell Plan that you are leaving or you will not be Disenrolled from Plan. Plan also encourages you to tell Plan why you left.
3. Your new plan will tell you the date when your membership in that plan begins. Remember, you are still a Member until your Disenrollment date with Plan, and must continue to get your medical care as usual through Plan until the date your membership ends.

Please note that ***any*** lapse in Coverage by a Plan sponsored or paid for, in part or in whole, by your employer will result in you losing eligibility for **all** such plans and your employer may never allow you, your spouse, or Dependent(s) to enroll in another Plan sponsored or paid for by your employer.

Until your membership officially ends, you must keep getting your Medicare services through the Plan or you will have to pay for them yourself

If you leave the Plan, it may take up to sixty (60) days for your membership to end and your new way of getting Medicare and/or other health care benefits to take effect (Plan discusses when the change takes effect later in this section). While you are waiting for your membership to end, you are still a Member and must continue to get your care as usual through Plan. If you get services from doctors or other medical providers who are **not** Plan providers before your membership in Plan ends, neither Plan nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are Urgently Needed Care, care for a Medical Emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by Plan. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Customer Service at the number on the cover of this

booklet to find out if your Hospital care will be covered by Plan. If you have any questions about leaving Plan, please call Customer Service.

All through the year, everyone with Medicare (including Members of Plan) is allowed to change from their current way of getting Medicare to one of their other choices all through the year. Special rules apply when you are covered by an Alternative Health Benefits Plan and you should contact your employer's benefits administrator for additional details on what, if any, plans are available to you. As Plan has explained above, you have one or more of the following choices about how you get your Medicare Coverage.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or "Fee-for-Service" health Plan that lets you go to any doctor, Hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Managed Care Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, Hospitals, and other providers that are part of the Plan. In PPOs, you can usually see any doctor but you may pay more to see doctors, Hospitals, and other providers that are not part of the Plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs. Plan is a Medicare managed care Plan offered by Plan. This choice is available to you if there are Medicare Managed Care Plans in your area, and if they are accepting new Members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Advantage plans must accept new Members (unless unusual circumstances apply). Plan offers other Medicare managed care plans other than the one sponsored or paid by your employer.
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to any Medicare-approved doctor or Hospital that accepts the Plan's payment. The Private Fee-for-Service Plan, rather than the Medicare program, decides how much it will pay and what you will pay for the services you will get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are not the same as Medigap (Medicare supplement insurance) policies. This choice is available to you if there are Medicare Private Fee-for-Service plans in your area, and if they are accepting new Members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new Members (unless unusual circumstances apply).
- **Alternative Health Benefit Plans** (such as HMOs and PPOs) may be available to you from your employer. These plans vary considerably in terms of cost, benefits, and eligibility and may cost you more money, but you may get extra benefits that none of the above options cover. Please contact your employer's benefits administrator for additional details on what, if any, Alternative Health Benefits Plans are available to you and how to enroll in these plans.

In most cases, your Disenrollment date will be the first day of the month that comes after the month Plan receives your request to leave. For example, if Plan receives your request to leave during the month of February, your Disenrollment date will be March 1. There is an exception: if Plan receives your request between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a Disenrollment date of December 1.

What should you do if you decide to leave the Plan?

If you want to leave Plan, what you must do to leave depends on whether you want to change to Original Medicare or to one of your other choices.

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Plan to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare Coverage. For Medigap advice, you should contact the Texas Department of Aging (TDoA) (the phone number is in the Introduction). You can ask TDoA about how and when to buy a Medigap policy if you need one. TDoA can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you have a **"guaranteed issue right,"** this means that the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a Medicare managed care Plan "trial period" and you change to Original Medicare. Generally, a Medicare managed care Plan trial period begins on the date of "first time" enrollment in a Medicare health Plan (other than Original Medicare) and ends 12 months later. You may be in a Medicare managed care Plan trial period if in the past 12 months you: (1) dropped a Medigap policy to join a Medicare health Plan for the first time; or (2) joined a Medicare health Plan upon first becoming entitled to Medicare at age 65. Under certain circumstances, if you lose your health Plan Coverage while you are still in a trial period, the trial period can last for an extra 12 months. TDoA can tell you about other situations where you may have guaranteed issue rights.

If you do buy a Medigap policy, you still have to follow the instructions below for changing from Plan to Original Medicare. (Buying a Medigap policy does not switch you from Plan to Original Medicare. A Medigap sales person or insurance agent cannot cancel your Plan membership and put you in Original Medicare.)

How to change from Plan to Original Medicare

If you decide to change from Plan to Original Medicare, you must tell Plan (or one of the offices listed below) that you want to leave Plan. You do not have to notify Original Medicare, because you will automatically be in Original Medicare when you leave Plan. Here is how it works:

1. First, use any of the following ways to tell Plan that you want to leave Plan:
   - You can write or fax a letter to Plan. Plan's fax number is 832-553-3419. Be sure to sign and date your letter.
   - You can call 1-800-MEDICARE, 24 hours a day/7 days a week (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048.
   - You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. The Introduction tells you how to contact these offices.
2. Plan will then send you a letter that tells you when your membership will end. This is your Disenrollment date – the day you officially leave Plan. In most cases, your Disenrollment date will be the first day of the month that comes after the month Plan receives your request to leave. For example, if Plan receives your request to leave during the month of February, your Disenrollment date will be March 1. There is an exception: the Disenrollment date for requests received between November 15 and

November 30 are effective on January 1, unless you specifically ask Plan to Disenroll you on December 1. Remember, while you are waiting for your membership to end, you are still a Member of Plan and must continue to get your medical care as usual through Plan.

3. On your Disenrollment date, your membership in Plan ends and you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will automatically be in Original Medicare when you leave Plan. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from the Plan to a Medicare managed care plan or to a Private Fee-for-Service plan

If you want to change from Plan to a different Medicare managed care Plan or to a different Private Fee-for-Service Plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new Members.
2. If the plan is accepting new Members, apply for membership in the plan. **Once you are enrolled in your new Plan, your membership in Plan will automatically end.** This means that you do not need to tell Plan that you are leaving. However, Plan does encourage you to tell Plan why you left.
3. Your new Plan will tell you in writing the date when your membership in that plan begins, and your membership in Plan will end on that same day (this will be your "Disenrollment date"). Remember, you are still a Member until your Disenrollment date, and must continue to get your medical care as usual through Plan until the date your membership ends.

What happens to you if the Plan leaves the Medicare program or the Plan leaves the area where you live?

If Plan leaves the Medicare program or changes the Service Area so that it no longer includes the area where you live, Plan will tell you in writing. If this happens, your membership in Plan will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this EOC will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Plan until your membership ends.

Your choices will always include Original Medicare. Your choices may also include joining another Medicare managed care Plan, Medicare a Private Fee-for-Service Plan, or another Alternative Health Benefits Plan, if these plans are available in your area and are accepting new Members. Once Plan has told you in writing that Plan is leaving the Medicare program or the area where you live, you may change to another way of getting your Medicare benefits at any time. If you decide to change from Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Plan or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for Plan's contract to end at some other time, too. If the contract is going to end, Plan will generally tell you 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end Plan's contract in the middle of the year.

You must leave the Plan if you move out of the Service Area or are away from the Service Area for more than six months in a row

If you Plan to move or take a long trip, please call Customer Service at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in Plan's Service Area. If you move permanently out of Plan's Service Area, or if you are away from Plan's Service Area for more than six months in a row, you will need to leave ("Disenroll" from) Plan. In these situations, if you do not leave on your own, Plan must end your membership ("Disenroll" you). An earlier part of this section tells about the choices you have if you leave Plan and explains how to leave.

Under certain conditions the Plan can end your membership and make you leave the Plan

Plan cannot ask you to leave the Plan because of your health

No Member of any Medicare health Plan can be asked to leave the Plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Plan because of your health, you should call 1-800-MEDICARE, 24 hours a day/7 days a week (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line.

Plan can ask you to leave the Plan under certain special conditions

If any of the following situations occur, Plan will need to end your membership in Plan.

- If you move out of Plan's geographic Service Area or live outside the Plan's Service Area for more than six months at a time (see Section 2 for information about the Plan's Service Area).
- If you do not stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 4 for information about staying enrolled in Part A and Part B).
- If you give Plan information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in Plan.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects Plan's ability to arrange or provide medical care for you or for others who are Members of Plan. Plan cannot make you leave Plan for this reason unless Plan gets permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your Plan membership card to get medical care. Before Plan asks you to leave Plan for this reason, Plan must refer your case to the Inspector General, and this may result in criminal prosecution.
- If there are Plan Premiums and if you or your employer does not pay the Plan Premiums, Plan will tell you that you have a 90-day grace period during which you can pay the Plan Premiums before you are required to leave Plan.

You have the right to make a complaint if Texas HealthSpring asks you to leave Plan

If Texas HealthSpring asks you to leave Plan, Texas HealthSpring will tell you of its reasons in writing and explain how you can file a complaint against Plan if you want to.

SECTION 6. Premiums, Copayments and Coinsurance - What you must pay for your Medicare health Plan Coverage and for the care you receive

Paying your share of the cost when you get Covered Services

Premium

- If you are required to make Premium payments for Coverage through your former employer, those Premium payments must be paid directly to your employer. You must continue to pay the appropriate Premiums for Medicare Part A and/or Part B to Medicare while enrolled in Plan.

What are "Copayments" and "Coinsurance"?

- A **"Copayment"** is a payment you make for your share of the cost of certain Covered Services you receive. A Copayment is a set amount per service (such as paying $10 for a PCP visit). You pay it when you get the service. The Benefits Chart in Section 7 gives your Copayments for Covered Services. Section 8 gives your Copayments for prescription drugs.
- **"Coinsurance"** is a payment you make for your share of the cost of certain Covered Services you receive. Coinsurance is **a *percentage* of the cost of the service** (such as paying 10% for Durable Medical Equipment). You pay your Coinsurance when you get the service. The Benefits Chart in Section 7 gives your Coinsurance for Covered Services.

What is the most you will pay for covered care?

There is a limit to how much you will have to pay for certain services each year. During the year, if the amount that you spend on specified services as a Member of Plan goes over $1,500, you are no longer subject to Copayments or Coinsurance for those services. The Out-of-Pocket Maximum chart in Section 7 lists services that are included in the Out-of-Pocket Maximum.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Plan. Other sections of this booklet tell about Covered Services and the rules that apply to getting your care as a Plan Member. With few exceptions, you must pay for services you receive from providers who are not part of Plan unless Texas HealthSpring has approved these services in advance. The exceptions are care for a Medical Emergency, Urgently Needed Care, out-of-area renal (kidney) dialysis services, and services that are found upon Appeal to be services that we should have paid or covered. (Sections 2 and 7 explain about using Plan Providers and the exceptions that apply.)

For Covered Services that have a benefit limitation, **you must pay the full cost of any services you get after you have exceeded your benefit for that type of covered service.** For example, you have to pay the full cost of SNF facility fees each day after you have exceeded the 100-day benefit limit; this would not include professional services, Texas HealthSpring would continue to cover approved professional services. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 7. Covered Services – How to obtain Your Health Care Services

What is a "Medical Emergency"?

A "Medical Emergency" is when **you reasonably believe that your health is in serious danger** -- when every second counts. A Medical Emergency includes severe pain, a bad Injury, a serious illness, or a Medical Condition that is quickly getting much worse.

What should you do if you have a Medical Emergency?

If you have a Medical Emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do not need to get permission first from your PCP (Primary Care Physician) or other Plan Provider.** (Section 2 tells about your PCP and Plan Providers.)
- Make sure that your PCP knows about your emergency, because your PCP will need to be involved in following up on your Emergency Care. You or someone else should call to tell your PCP about your Emergency Care as soon as possible, preferably within 48 hours. Your PCP's phone number is listed on the front of your membership card.

Your PCP will help manage and follow up on your Emergency Care

Your PCP will talk with the doctors who are giving you Emergency Care to help manage and follow up on your care. When the doctors who are giving you Emergency Care say that your condition is stable and the Medical Emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, your PCP will try to arrange for Plan Providers to take over your care as soon as your Medical Condition and the circumstances allow.

What is covered if you have a Medical Emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn't really a Medical Emergency?

Sometimes it can be hard to know if you have a real Medical Emergency. For example, you might go in for Emergency Care -- thinking that your health is in serious danger -- and the doctor may say that it was not a Medical Emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'Medical Emergency'" above). However, please note that:

- If you get any additional care after the doctor says it was not a Medical Emergency, we will pay our portion of the covered additional care **if you get it from a Plan Provider**.
- If you get any additional care from a *Non-Plan Provider* after the doctor says it was not a Medical Emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a Non-Plan Provider if you are out of our Service Area, as long as the additional care you get meets the definition of "Urgently Needed Care" that is given below.

What is "Urgently Needed Care"? (this is different from a Medical Emergency)

"Urgently needed care" is when **you need medical attention right away for an unforeseen illness or Injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other Plan Providers. In these cases, your health is not in serious danger. As we explain below, how you get "Urgently Needed Care" depends on whether you need it when you are in the Plan's Service Area, or outside the Plan's Service Area. Section 2 tells about the Plan's Service Area.

What is the difference between a "Medical Emergency" and "Urgently Needed Care"?

The main difference between an urgent need for care and a Medical Emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "Medical Emergency" is if you believe that your health is in serious danger.

Getting Urgently Needed Care when you are <u>in</u> the Plan's Service Area

If you have a sudden illness or Injury that is not a Medical Emergency, and you are in the Plan's Service Area, please call your PCP. There will always be a doctor on call to help you. Keep in mind that if you have an urgent need for care while you are in the Plan's Service Area, we expect you to get this care from Plan Providers. In most cases, we will not pay for Urgently Needed Care that you get from a Non-Plan Provider while you are in the Plan's Service Area.

Getting Urgently Needed Care when you are <u>outside</u> the Plan's Service Area

Plan covers Urgently Needed Care that you get from Non-Plan Providers when you are outside the Plan's Service Area. If you need urgent care while you are outside the Plan's Service Area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the Service Area, we prefer that you return to the Service Area to get follow-up care through your PCP. However, we will cover follow-up care that you get from Non-Plan Providers outside the Plan's Service Area as long as the care you are getting still meets the definition of "Urgently Needed Care."

As explained in Section 2, we cover renal (kidney) dialysis services that you get when you are temporarily outside the Plan's Service Area (for up to six months in a row).

Benefits Chart – a list of the Covered Services you get as a Member of Plan

What are "Covered Services"?

This section describes the medical benefits and Coverage you get as a Member of Plan. **"Covered Services" means the medical care, services, supplies, and equipment that are covered by Plan.** This section lists services included in the Out-of-Pocket Maximum and a Benefits Chart that gives a list of your Covered Services and tells what you must pay for each covered service. Section 9 tells about **services that are *not* covered** (these are called "exclusions").

There are some conditions that apply in order to get Covered Services

Some general requirements apply to all Covered Services

The Covered Services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare Coverage guidelines established by the Medicare program.

- The medical care, services, supplies, and equipment that are listed as Covered Services must be Medically Necessary. Certain preventive care and screening tests are also covered.
- With few exceptions, Covered Services must either be provided by Plan Providers, be approved in advance by Plan Providers, or be authorized by Texas HealthSpring. The exceptions are care for a Medical Emergency, Urgently Needed Care, and renal (kidney) dialysis you get when you are outside the Plan's Service Area.

In addition, some Covered Services require "Prior Authorization" in order to be covered

Some of the Covered Services listed in the Benefits Chart in this section are covered only if your doctor or other Plan Provider gets "Prior Authorization" (approval in advance) from Texas HealthSpring. Covered Services that need Prior Authorization are marked in the Benefits Chart.

What is your Out-of-Pocket Maximum?

This is the maximum annual out-of-pocket cost you pay for Copayments and Coinsurance for specified services. **Once the Out-of-Pocket Maximum has been met, you no longer pay Copayments or Coinsurance for the following Plan services. Physician services do NOT apply to the Out-of-Pocket Maximum.**

Out-of-Pocket Benefit Chart – *a list of services that apply to your Out-of-Pocket Maximum:*

Out-of-Pocket Maximum The Out-of-Pocket Maximum does not include physician services	**There is a $1,500 maximum out-of-pocket limit every year for the Plan services listed below . Once the Out-of-Pocket Maximum has been met, you no longer pay Copayments or Coinsurance for the following Plan services :** • Inpatient Hospital Care • Inpatient Mental Health Care • Skilled Nursing Facility • Home Health Care • Chiropractic Services • Podiatry Services • Outpatient Mental Health Care • Outpatient Substance Abuse Care • Outpatient Services • Ambulance Services • Emergency Care • Urgently Needed Care • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training and Supplies • Diagnostic Tests, X-Rays, and Lab Services • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Cardiac Rehabilitation Services • Renal Dialysis

Benefits chart – A list of the Covered Services you get as a Member of the Plan

INPATIENT SERVICES	
Inpatient Hospital care For more information about Hospital care, see the end of this section. Covered Services include, but are not limited to, the following: • Semiprivate room (or a private room if Medically Necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation Services, such as physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. Additional information about transplants is included in this section. • Blood – Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need. • Physician services.	$275 per admission Medicare covered stay in a network Hospital. You are covered for unlimited days. If you are re-admitted to the Hospital within 3 days for the same diagnosis your Copayment will be waived.
Inpatient mental health care Includes mental health care services that require a Hospital stay. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a Hospital.	$275 per admission for a Medicare-covered stay in network Hospital. 190-day lifetime limit in a psychiatric Hospital.

Skilled nursing facility care For more information about Skilled Nursing Facility care, see the end of this section.	
Three day Hospital stay prior to admission to a Skilled Nursing Facility is not required. Covered Services include, but are not limited to, the following:	$25 for day(s) 1-100 for a Medicare-covered stay in a network facility.*
• Semiprivate room (or a private room if Medically Necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood – including storage and administration. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	100 days per Benefit Period. (See definition in Section 3). *Two exceptions for non-network facilities are listed on page 46
Inpatient Services (when the Hospital or SNF days are not or are no longer covered) For more information, see the end of this section. Plan continues to pay for the following services:	You pay 100 % for facility charges.
• Physician services.	You pay $10 for each PCP visit and $25 for each Specialist visit for Medicare-Covered Services.
• Diagnostic tests (like X-ray or lab tests).	You pay $0 Copayment
• X-ray, radium, and isotope therapy including technician materials and services.	$25 Copayment for each Medicare-covered radiation therapy service.
• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.	$0 Copayment
• Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.	20 % Coinsurance for the cost of each Medicare-covered item.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.	20 % Coinsurance for the cost of each Medicare-covered item.
• Physical therapy, speech therapy, and occupational therapy.	$25 Copayment for each Medicare-covered therapy visit.

Home health care For more information about home health care, see the end of this section. **Home Health Agency Care:** • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	$0 Copayment for Medicare-covered home health visits.
Hospice care For more information about hospice services, see the end of this section. Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare are covered. Home Care is also covered (depending on the situation). Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	You must receive care from a Medicare-covered hospice and the Copayment is $0.
Transplants	You pay $912 per confinement (up to 60 days). You pay $228 per day (for days 61 – 90). You pay $456 per each lifetime reserve day (maximum 60 lifetime reserve days). (This replace the inpatient copayment for a hospital confinement)
OUTPATIENT SERVICES	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a Specialist. • Second opinion by another Plan Provider prior to surgery. • Outpatient Hospital services. • Non-routine dental care (Covered Services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor).	You pay $10 for each PCP office visit for Medicare-Covered Services. You pay $25 for each Specialist visit for Medicare-Covered Services.

Chiropractic services • Manual manipulation of the spine to correct subluxation.	$25 Copayment for each Medicare-covered visit
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for Members with certain Medical Conditions affecting the lower limbs.	$25 Copayment for each Medicare-covered visit (Medically Necessary foot care)
Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse Specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient Hospitalization.	$25 Copayment for each individual/ group therapy visit for Medicare-Covered Services
Outpatient Substance Abuse Services	$25 Copayment for each individual/ group visit for Medicare-Covered Services
Outpatient surgery	$200 Copayment for each Medicare-covered visit or procedure to an ambulatory surgical center. $200 Copayment for each Medicare-covered visit to an outpatient Hospital facility.
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	$100 Copayment for each one way trip for a Medicare-covered ambulance service. You do not pay this Copayment if you are admitted to the Hospital.
Emergency Care For more information, see the beginning of this section. • Covered inpatient or outpatient services that are 1) given by a provider qualified to give emergency services; and 2) needed to evaluate or stabilize a Medical Emergency condition. • Worldwide Coverage.	$50 Copayment for Medicare-covered emergency room visit. You do not pay this amount if you are admitted to the Hospital **within 3 days** for the same condition. If you get inpatient care at a non-Plan Hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a Plan Hospital with Plan authorization.

Urgently needed care For more information, see the beginning of this section. • Worldwide	$40 Copayment for each Medicare-covered Urgently Needed Care visit; waived if admitted within 3 days.
Outpatient Rehabilitation Services **(physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)** Including Comprehensive Outpatient Rehabilitation Facility Services.	$25 Copayment for each Medicare-covered occupational therapy visit.
Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	$25 Copayment for each Medicare-covered physical therapy and/or speech/language therapy visit.
Durable Medical Equipment and related supplies such as wheelchairs, crutches, Hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "Durable Medical Equipment" in Section 3)	10 % Coinsurance for the cost of each Medicare-covered item.
Prosthetic devices and related supplies (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail.	20 % Coinsurance for the cost of each Medicare-covered item.
Diabetes self-monitoring, training and supplies for all people who have diabetes (insulin and non-insulin users).	
Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.	20 % Coinsurance for diabetic supplies.
One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.	Injectable insulin – you pay $10 (Generic) or $30 (brand) for 30-day supply.
Self-monitoring training is covered under certain conditions.	$0 Copayment diabetes self-monitoring training
Self Management Training For persons at risk of diabetes: Fasting plasma glucose test. Contact Customer Service for information on how often we will cover these tests.	There is no Copayment for self-management training.

Outpatient diagnostic tests and therapeutic services	
• X-rays.	$0 Copayment for a Medicare-covered x-ray visit.
• Outpatient radiation therapy.	$25 Copayment for each Medicare-covered radiation therapy service.
• Laboratory tests.	$0 Copayment for each Medicare-covered clinical/ diagnostic lab service.
• CT, MRI, Cardiac Nuclear Medicine	$100 Copayment for each Medicare-covered CT, MRI, Cardiac Nuclear Medicine.
• PET Scan.	$150 Copayment for each Medicare-covered PET Scan.
• Renal Dialysis services (including renal dialysis services when temporarily out of the Plan's Service Area, as explained in Sections 2 and in this section)	$25 Copayment for each Specialist visit
PREVENTIVE CARE AND SCREENING TESTS	
Bone mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if Medically Necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 Copayment
Colorectal screening *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people not at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 2 years.	$0 Copayment

Immunizations • Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a Referral from your PCP *as long as you get the service from a Plan Provider.*	$0 Copayment
• Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a Referral from your PCP *as long as you get the service from a Plan Provider.*	$0 Copayment
• *If you are at high or intermediate risk of getting Hepatitis B:* Hepatitis B vaccine.	$0 Copayment
• Other vaccines if you are at risk such as anti-rabies vaccine if you may have been exposed to rabies.	$0 Copayment
Mammography screening (as explained in Section 2, you can get this service on your own, without a Referral from your PCP *as long as you get it from a Plan Provider:* • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	$0 Copayment for Medicare-covered screening mammograms. No Referral necessary for Medicare-covered screenings.
Pap smears, pelvic exams, and clinical breast exam (as explained in Section 2, you can get these routine women's health services on your own, without a Referral from your PCP *as long as you get the services from a Plan Provider:* • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	$0 Copayment for Medicare-covered pap smears or pelvic exams.
Prostate cancer screening exams *For men over age 50, the following are covered once every 12 months:* • Digital rectal exam • Prostate Specific Antigen (PSA) test	$0 Copayment for Medicare-covered prostate cancer screening exams.
Cardiovascular screening blood tests Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for information on how often we will cover these tests.	$0 Copayment for Medicare-covered tests.

OTHER SERVICES	
Renal Dialysis (Kidney)	
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the Service Area, as explained in Sections 2 and in this section).	$25 Copayment for each Specialist visit included under inpatient benefits
• Inpatient dialysis treatments (if you are admitted to a Hospital for special care).	$0 Copayment
• Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments).	$0 Copayment
• Home dialysis equipment and supplies.	20% Coinsurance
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	$25 Copayment
Drugs that are covered under Original Medicare **(these drugs are covered for everyone with Medicare)** "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Plan also covers some drugs that are "usually not self-administered" even if you inject them at home. • Allergy injections • Drugs you take using Durable Medical Equipment (such as nebulizers) that was authorized by Texas HealthSpring. (See Section 3 for a definition of "Durable Medical Equipment). • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparing, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Rpoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	15% Coinsurance for Medicare-covered drugs and biologicals; $1,000 annual Out-of-Pocket Maximum.

OTHER SERVICES *(continued)*	
Drugs that are covered under Original Medicare (continued) The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, Plan offers an outpatient prescription drug benefit. This additional benefit is described below under the heading that says, "Plan Prescription Drug Benefit (Outpatient prescription drugs.)"	
ADDITIONAL BENEFITS	
Plan Prescription Drug Benefit *(outpatient prescription drugs)* "Drugs" include substances that are naturally present in the body such as blood factors and insulin. **The Plan prescription drug benefit covers the following:** • Certain outpatient prescription drugs. Section 8 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 8 also tells about drugs that are not covered by this benefit. • You must use designated retail pharmacies to get your prescriptions or the designated mail order services. • Certain classifications of drugs have quantity limits and/or are subject to prior approval. Authorization may be required for prescription drugs. • Formulary may change quarterly based on a review by Texas HealthSpring. Changes may include, but are not limited to, changes in preferred versus non-preferred status for medications, prior authorization requirements, and implementation of step therapy.	Retail Copayment per 30-day supply: $10 Generic drug $30 preferred drug $45 non-preferred drug $45 out of area drug Mail Order Copayment per 90-day supply: $20 Generic drug $60 preferred drug $90 non-preferred drug $90 out-of-area $4,000 combined annual limit for retail and mail-order preferred and non-preferred brand name prescriptions.
Dental services • Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	Value added discount program that provides a discount up to 70% for certain dental services at selected providers.
Hearing services • Diagnostic hearing exams. • Hearing aid - $1,000 towards the purchase of hearing aid device(s) every 36 months. Limited to one per ear every 36 months. Batteries are not covered except at the time of the initial placement of the hearing aid device. • Routine hearing exams are exams not related to a specific problem. • Diagnostic hearing exams are exams related to specific symptoms or problems.	You pay 100% for routine hearing exams and hearing aids. $25 for each Medicare-covered hearing exam (diagnostic). Value added discount program that provides a discount up to 30% for hearing tests and hearing aid at selected providers.

Vision care – for treatment/diagnosis of eye disease. This is not an exam for vision correction via prescription lenses. • Outpatient physician services for eye care. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	$0 Copayment for: Medicare-covered eyewear (one pair of glasses or contacts after each cataract surgery). You pay $25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
Routine physical exams	$10 Copayment, up to one per year
Health and Wellness Education	Multiple disease management and wellness programs are included.
Transportation	$0 Copayment per each one-way trip up to 15 round trips to Plan-approved locations every year

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a Member, we want to help. Please call us at Customer Service at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 12 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. We can increase your benefits at any time during the calendar year (the current calendar year is the period from May 1, 2005 through December 31, 2005). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a Copayment, Coinsurance, or Plan Premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any decreases we make in your benefits. We will tell you in advance if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2006.

At any time during the year, the Medicare program can change its national Coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug Formulary list at any time during the calendar year. As we explain in Section 8, the Formulary is a list of drugs. A change in our Drug Formulary list could result in the addition of newly eligible drugs or the elimination of drugs from the Plan Formulary for drugs that have been approved for over-the-counter distribution. Note that the Formulary list applies only to the Covered Services listed in the Benefits Chart under the heading that says, "Plan Prescription Drug Benefit (outpatient prescription drugs)."

Hospital care, Skilled Nursing Facility care, and other services (this section gives additional information about some of the Covered Services that are listed in the Benefits Chart)

Hospital care

If you need Hospital care, we will arrange Covered Services for you. Covered Services are listed in the Benefits Chart in this section under the heading "Inpatient Hospital Care." We use "Hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "Hospital" does not include facilities that mainly provide Custodial Care (such as convalescent nursing homes or rest homes). By "Custodial Care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What is a "Benefit Period" for Hospital care?

Plan does not use Benefit Periods to determine your Coverage for inpatient services during a Hospital stay (generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital).

Later in this section we explain about SNF services. Please note that after your SNF Hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in this section under the heading, "Inpatient services (when the Hospital or SNF days are not or are no longer covered)."

What happens if you join or drop out of Plan during a Hospital stay?

If you either join or leave Plan during an inpatient Hospital stay, special rules apply to your Coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Service at the telephone number on the cover of this booklet. Customer Service can explain how your services are covered for this stay, and what you owe to Texas HealthSpring, if any, for the periods of your stay when you were and were not a Plan Member.

What is a "Hospitalist"?

A Hospitalist is a physician who specializes in treating patients in a Hospital setting and who may coordinate a patient's care when he or she is admitted at a contracting Texas HealthSpring Hospital. This physician may oversee your care while hospitalized and coordinate care with your Primary Care Physician and other Specialists.

Skilled nursing facility care (SNF care)

If you need Skilled Nursing Facility care, we will arrange these services for you. Covered Services are listed in the Benefits Chart in this section under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your Covered Services.

A Skilled Nursing Facility is **a place that provides skilled nursing or skilled Rehabilitation Services** to help you recover after a Hospital stay. It can be a separate facility, or part of a Hospital or other health care facility. A **Skilled Nursing Facility** is called a "SNF" for short. The term "Skilled Nursing Facility" does not include places that mainly provide Custodial Care, such as convalescent nursing homes or rest homes. (By "Custodial Care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is Skilled Nursing Facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled Rehabilitation Services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled Rehabilitation Services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide Custodial Care only are not covered

"Custodial care" is care for personal needs rather than Medically Necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Plan unless it is provided as other care you are getting ***in addition*** to daily skilled nursing care and/or skilled Rehabilitation Services.

There are Benefit Period limitations on Coverage of Skilled Nursing Facility care

Inpatient Skilled Nursing Facility Coverage is limited to 100 days each Benefit Period. There is no limit to the number of admissions.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in this section under the heading, "Inpatient services (when the Hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a Plan Provider

Generally, you will get your Skilled Nursing Facility care from SNFs that are Plan Providers for Plan. However, ***if certain conditions are met***, you may be able to get your Skilled Nursing Facility care from a SNF that is not a Plan Provider. One of the conditions is that the SNF that is not a Plan Provider must be willing to accept Texas HealthSpring's rates for payment. At your request, we may be able to arrange for you to get your Skilled Nursing Facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the Hospital (as long as the place gives Skilled Nursing Facility care and is Medicare certified).
- A Medicare certified SNF where your spouse is living at the time you leave the Hospital.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or Injury. Covered Services are listed in the Benefits Chart in this section under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or Injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a Plan for your care at home. Your **Plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

3. The Home Health Agency caring for you must be approved by the Medicare program.

4. **You must need *at least one* of the following types of skilled care:**
   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are also included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or Injury, and they are not covered unless you are also getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a Hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a Member of Plan, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Customer Service at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at 1-800-MEDICARE (1-800-633-4227.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Plan) pays the hospice for the hospice services you receive. Your hospice doctor can be a Plan Provider or a Non-Plan Provider. If you choose to enroll in a Medicare-certified hospice, you are still a Plan Member and continue to get the rest of your care that is unrelated to your terminal condition through Plan. If you use non-plan providers for your routine care, Original Medicare (rather than Texas HealthSpring) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some Hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare Coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Plan) pays the clinical trial doctors and other providers for the Covered Services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Plan and continue to get the rest of your care that is

unrelated to the clinical trial through Plan. You will have to pay the Original Medicare Coinsurance for the clinical trial services.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do ***not*** need to get a Referral from a Plan Provider to join a clinical trial, and the clinical trial providers do ***not*** need to be Plan Providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Plan under certain conditions. Covered Services in a RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in a RNHCI, you must have a Medical Condition that would allow you to receive inpatient Hospital care or extended care services or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not Religious Non-medical Health Care Institutions. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Plan, or your stay in the RNHCI may not be covered.

SECTION 8. Prescription drugs *(this section gives additional information about the outpatient prescription drug benefit that is listed in the Benefits Chart in Section 7)*

Introduction to the Plan outpatient prescription drug benefit

The purpose of this section is to give details about the Plan outpatient prescription drug benefit. This benefit is listed in the Benefits Chart in Section 7 under the heading, "Plan prescription drug benefit (outpatient prescription drugs)." This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (FDA). **Your comprehensive outpatient prescription drug benefit has a three-tiered Copayment structure including $10 for Generic medications, $30 for preferred brand medications and $45 for non-preferred brand medications. The prescription drugs covered under the Plan are listed in the Formulary (please see Definitions). There is a $4,000 combined annual limit for retail and mail-order preferred and non-preferred brand name and prescription drugs. This Formulary provides you and your physician with the ability to make choices regarding which prescription medication best suits your needs.**

With few exceptions, your prescriptions must be from Plan Providers and must be filled at a Plan pharmacy or through our mail order service

In nearly all cases, your prescriptions are covered only if they are written or ordered by a Plan doctor or other Plan Provider. In addition, as we explain later on, you must fill your prescriptions at certain pharmacies or through our own mail order pharmacy service. There is an exception for medical emergencies and Urgently Needed Care. If it is a Medical Emergency or Urgently Needed Care, we cover prescriptions you get from doctors who are not Plan Providers and prescriptions that are filled at non-Plan pharmacies. Section 7 tells about care for a Medical Emergency and Urgently Needed Care.

The Plan Formulary list tells which drugs are covered by the prescription drug benefit

The Plan Formulary is a list of prescription drugs (including insulin) that Plan doctors refer to when they need to prescribe drugs. Often they prescribe drugs that are included on the Formulary list, but sometimes they prescribe drugs that are not on the list.

As we explain a little later, **in nearly all cases, your prescriptions are covered only if the drug is included on the Formulary list.**

The Plan Formulary list was created by a group of doctors and pharmacists. They picked the drugs that are on this Formulary list **based on how safe and effective they are, and how much they cost.** We call the drugs that are on this list "Formulary drugs." We call drugs that are ***not*** on the list "non-Formulary drugs." To get a copy of the Formulary list, call Texas HealthSpring Customer Service at 832-553-3480 or toll-free 800-280-8888l, TTY users should call 877-893-1504, Monday through Friday, 8:00 am to 5:00 pm Central Time. The Formulary list is also available on the Texas HealthSpring web site on the Internet at www.texashealthspring.com.

The Formulary list includes selected Generic and brand name prescription medications

Generic drugs are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A Generic drug is a lower cost version of a brand name drug. Some brand-name drugs have a Generic equivalent and others do not.

Brand-name drugs are drugs that are produced and sold under the original manufacturer's brand name.

Generic drugs cost less, but **Generic and brand-name drugs are the same in terms of quality and**

how they work. The law requires that a Generic drug must contain the same amount of the same active drug ingredient as the brand-name drug. However, a Generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains.

The Plan Formulary list includes most multi-source Generic drugs as well as representative brand names in each drug classification.. Texas HealthSpring's Plan pharmacies and mail order service fill prescriptions using Generic drugs rather than brand-name drugs whenever possible to assist you in managing costs.

How much do you pay when you fill a prescription?

The amount you pay when you fill a covered prescription is called your **Copayment.**

When you fill a prescription, you pay either the Copayment listed below, or you pay the full cost of the prescription – whichever is *lower.*

- **There is a limit on how much of the drug you can get for one Copayment.** For most oral medications, such as pills or other drugs that you swallow, the maximum is a 30 day supply. For medications other than ones you swallow, the maximum depends on the type of medication. The maximum amount per Copayment might be a single container, inhaler unit, package, or course of therapy. For example, you would have to pay two Copayments if you got two inhalers. If your doctor prescribes an amount of medication that is smaller than the maximum allowed for a single Copayment, you must still pay the full Copayment.
- If you fill the prescription through our mail order service, there is one mail order Copayment for a 3 month supply. By mail, you must order a 90-day supply. For drugs that are included on the Formulary list, here are your Copayments:

	Retail Copayment	Mail Order Copayment
Generic Drug	$10	$20
Preferred Drug	$30	$60
Non-Preferred Drug	$45	$90
Out-of-Area Drug	$45	$90

If the drug is available through our mail order service, there will be one Mail Order Copayment per 90-day supply if you get it by mail. There is a $4,000 combined annual limit for retail and mail-order preferred and non-preferred brand name and prescription drugs.

Important things to know about the Formulary list and how much you pay

Since the Formulary list can change during the year, there could be changes in the drugs available to you

A committee of doctors and pharmacists reviews and updates the Plan Formulary list quarterly throughout the year. This means that drugs can be added to or dropped from the Formulary list at that time. Drugs can also be changed from one category of drugs to another within the Formulary. Changes in the Formulary list can affect which drugs are covered for you. You can call our Customer Service Department at the number listed on the front of this booklet to find out if your drug is on the Formulary list or to get a copy of the Formulary list.

During the year, we use newsletters to tell doctors and Plan Members about changes in the Formulary list.

Filling your prescriptions at a Plan pharmacy or through our mail order service

Filling prescriptions at a Plan pharmacy

To get a list of the pharmacies you can use, call Customer Service at the number listed on the front of this booklet. We call the pharmacies on this list our "Plan pharmacies" because we have made arrangements with them to handle prescriptions for Members of Plan.

To use your prescription drug benefit, you must show your Plan ID card at one of our Plan pharmacies. If you do not have your ID card with you when you fill the prescription, you will have to pay the ***full cost*** of the prescription (rather than paying just your Copayment). If this happens to you, you can ask us to reimburse you for our share of the cost by filling out a pharmacy claim form and sending it to us. To get a claim form and more information, call our Customer Service Department at the number listed on the front of this booklet.

If you are a new Member and need to have an existing prescription refilled, remember that the prescription must be written by Plan Provider or it will not be covered (even if you fill it at a Plan pharmacy). You should consult with your current doctor to see if he or she wants you to continue on the medication, and you must get a new prescription from your current doctor.

Using the Plan mail order pharmacy service

To get order forms and information about filling your prescriptions by mail, call Customer Service Department at the number listed on the front of this booklet. Please note that you must use the Plan mail order service. Prescription drugs that you get at any other mail order service are not covered.

When you order prescription drugs by mail, you must order at least a 90-day supply.

Things to know about getting your prescriptions filled

If you fill your prescription at a pharmacy that is not a Plan pharmacy, you will have to pay the full cost of the prescription yourself, and we will not pay for any part of the cost. There is an exception: prescriptions filled at a non-Plan pharmacy are covered if they are related to care for a Medical Emergency or Urgently Needed Care. In this situation, you can ask us to pay our share of the cost by filling out a pharmacy claim form and sending it to us within 90 days. To get a claim form and more information, call our Customer Service Department at the number listed on the front of this booklet.

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. If you Plan to be away for three months or less, you may be able to order your prescription drugs ahead of time through the Plan mail order pharmacy, or refill your prescriptions at a Plan pharmacy away from home. To find out if there is a Plan pharmacy in the area you will be visiting, call our Customer Service Department at the number listed on the front of this booklet.

Prescription drug benefit exclusions (drugs that are not covered)

The following list shows some of the types of drugs or categories of drugs are not covered. These are called "exclusions." Also, see Section 7 (Benefits chart – a list of the Covered Services you get as a Plan Member), Section 9 ("Medical care and services that are not covered – a list of exclusions"), and the Formulary list for more information about drugs that are not covered.

- **Botox**
- **Over the Counter (OTC) Generic drug equivalents** - Patent, over the counter (OTC) medicines, or medicines not requiring a written prescription order that also have a Generic drug equivalent.
- **Lifestyle Medications**- Medicines whose primary function is to enhance or modify a person's lifestyle. Examples of Lifestyle medications include, but are not limited to drugs to enhance sexual performance, weight loss medications, cosmetic medications, hair loss medicines etc.

How to get help with questions or problems related to your prescription drug Coverage

To learn more about your prescription drug benefits, call our Customer Service Department at **832-553-3480** locally, or **800-280-8888** toll-free; TTY users should call **877-893-1504**; Monday through Friday, 8:00 am to 5:00 pm Central Time or visit our website at www.texashealthspring.com.

From time to time, Texas HealthSpring may make decisions that affect your prescription drug Coverage, such as whether a particular drug is covered for you, or whether we approve your doctor's request for an exception to the usual rules about prescription drug Coverage. If you are unhappy about a decision we make about whether a prescription is covered, or the amount of payment for a prescription, you have the right to make an Appeal (an Appeal asks us to reconsider and change our decision about Coverage or payment). If you want to make any ***other*** types of complaints related to your prescription drug benefit, you would file a "Grievance." Section 12 discusses Grievances and Appeals. You can also call Customer Service to get additional information or help with a Grievance or Appeal.

SECTION 9. Medical care and services that are NOT covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by Plan. The list below tells about these exclusions and limitations. The list describes services that are not covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 7 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon Appeal to be services that we should have paid or covered (Appeals are discussed in Section 12).

What services are not covered by the Plan?

In addition to any exclusions or limitations described in the Benefits Chart in Section 7, or anywhere else in this booklet, **the following items and services are not covered by Plan:**

1. Services that are not covered under Original Medicare, ***unless*** such services are specifically listed as covered in Section 7.
2. Services that you get from Non-Plan Providers, ***except*** for care for a Medical Emergency and Urgently Needed Care, renal (kidney) dialysis services that you get when you are temporarily outside the Plan's Service Area, and care from Non-Plan Providers that is arranged or approved by a Plan Provider. See other parts of this booklet (especially Sections 2 and 7) for information about using Plan Providers and the exceptions that apply.
3. Services that you get without a Referral from your PCP, when a Referral from your PCP is required for getting that service.
4. Services that you get without Prior Authorization, when Prior Authorization is required for getting that service. (Sections 3 & 7 gives a definition of Prior Authorization and tells which services require Prior Authorization.)
5. Services that are not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. As noted in Section 7, we provide all Covered Services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a Medical Emergency. (See Section 7 for more information about getting care for a Medical Emergency).
7. Experimental or Investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental Procedures and items are those items and procedures determined by Texas HealthSpring and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a Member of Plan.
8. Surgical treatment of morbid obesity ***unless*** Medically Necessary and covered under Original Medicare.
9. Private room in a Hospital, ***unless*** Medically Necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility.

12. Nursing care on a full-time basis in your home.
13. Custodial care is not covered by Plan ***unless*** it is provided in conjunction with skilled nursing care and/or skilled Rehabilitation Services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaker services.
15. Charges imposed by immediate relatives or Members of your household.
16. Meals delivered to your home.
17. Unless Medically Necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
18. Cosmetic surgery or procedures, ***unless*** it is needed because of accidental Injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
19. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the Hospital will be covered.
20. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in Section 7) and is limited according to Medicare guidelines.
21. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
22. Orthopedic shoes, ***unless*** they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 7, in the Benefits Chart under "Diabetes Self-Monitoring Training and Supplies").
23. Supportive devices for the feet. ***There is an exception:*** orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 7, in the Benefits Chart under "Diabetes Self-Monitoring Training and Supplies").
24. Routine hearing examinations.
25. Routine eye examinations and eyeglasses (***except*** after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
26. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
27. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically Necessary services for infertility are covered according to Original Medicare guidelines.)
28. Acupuncture.
29. Naturopaths' services.
30. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA Hospital, if the VA cost sharing is more than the cost sharing required under the Plan, we will reimburse veterans for the difference. Members are still responsible for the Plan's cost sharing amount.

SECTION 10. Procedures For Reimbursement

What should you do if you have bills from Non-Plan Providers that you think we should pay?

As explained in Sections 2 and 7, we cover certain health care services that you get from Non-Plan Providers. These include care for a Medical Emergency, Urgently Needed Care, renal dialysis that you get when you are outside the Plan's Service Area, care that has been approved in advance by Texas HealthSpring, and services that we denied but that were overturned in an Appeal. If a Non-Plan Provider asks you to pay for Covered Services you get in these situations, please contact Customer Service at the number listed on the cover of this booklet. It is best to ask a Non-Plan Provider to bill us first, but if you have already paid for the Covered Services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-Plan Provider any more than what he or she would have received from you if you had been covered with Original Medicare.

SECTION 10.1 PAYMENT OF ELIGIBLE EXPENSES FROM CONTRACTED PROVIDERS.

Contracted providers are responsible for submitting a request for payment of Eligible Expenses directly to Plan. In the event you are billed by a contracted provider for Eligible Expenses beyond your Copayment or Coinsurance amount, you should contact Customer Service at 832-553-3480 locally, or 1-800-280-8888 toll free or TTY at 1-877-893-1504 toll free.

SECTION 10.2 PAYMENT OF ELIGIBLE EXPENSES FROM NON-CONTRACTED PROVIDERS.

Plan will pay for Eligible Expenses received from non-contracted providers only for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services and Urgently Needed Health Services, or Covered Services approved by Plan in accordance with the terms of this EOC. Non-contracted providers should submit bills to Plan for payment. However, if you paid for such Covered Services from a non-contracted provider you should contact Customer Service. You are required to pay any Copayment or Coinsurance amount required under the EOC for those Covered Services.

If you paid for Covered Services directly to the non-contracted provider and you are submitting a request for reimbursement, please follow these steps to be reimbursed for Eligible Expenses:

- Send a request for reimbursement for Covered Services to Plan as soon as possible but no later than the time limits specified in the table below:

For services received between:	**Submit your request by:**
Jan. 1 and Sept. 30	**Dec. 31 of the year following the year in which services were received.**
Oct. 1 and Dec. 31	**Dec. 31 of the second year following the year in which services were received**.

- The request for reimbursement must be presented in a letter with an itemized statement (an explanation of the situation, the bill, and a receipt or canceled check) for the Covered Services.

- The request for reimbursement of Eligible Expenses can be submitted to Plan at the following address:

  FAX 832-553-3419

  WRITE Texas HealthSpring
  PO Box 922002
  Houston, TX 77292-2002

  VISIT 2900 North Loop West – Suite 1300
  Houston, TX 77092

- Within 15 days after Plan receives your written request for reimbursement, Plan will:
  (a) acknowledge receipt of the request for reimbursement;
  (b) begin any investigation of the request for reimbursement;
  (c) specify additional information you must provide for the reimbursement. (Plan can request additional information during the investigation, if necessary).
- Within 15 business days after Plan receives all the information required to approve the request for reimbursement, Plan will:
  (a) give you written notice that your request for reimbursement has been accepted and reimburse you within five (5) business days after notification of acceptance; or
  (b) give you written notice that your request for reimbursement has been rejected and tell you the reason(s) for the rejection; or
  (c) give you written notice if Plan needs more time to make the decision and the reasons needed for the additional time. However, Plan will notify you of the final decision within 45 days from the date of receipt.

Plan will reimburse you for accepted Covered Services you have paid for usually within 30 calendar days, but no more than 60 calendar days, upon receipt of written proof of loss. Subject to your written authorization, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Covered Services instead of being paid to you.

Plan will advise you of Plan's determination, in writing, regarding requests for reimbursement that have a defect, impropriety, lack of any required substantiating documentation, or the particular circumstances requiring special treatment that prevent timely payment, usually within 30 calendar days but no more than 60 calendar days, after receipt of the request for reimbursement. All other requests for reimbursement of Eligible Expenses will be paid by Plan within 30 calendar days, but no more than 60 calendar days, after receipt of the request for reimbursement.

SECTION 10.3 LIMITATION OF ACTION FOR REIMBURSEMENT.

No legal proceeding or action may be brought to recover reimbursement prior to the expiration of 60 days after a request for reimbursement has been properly submitted as described above. If you do not bring such legal proceeding or action against Plan within 3 years of the expiration date described above, you forfeit your rights to bring any action against Plan. Exceptions to this limitation include the time limits set forth in Section 12 that apply to the Medicare Appeals Process.

SECTION 11. Coordination of Benefits and Subrogation

Please keep us up-to-date on any other health insurance Coverage you have

Using *all* of your insurance Coverage

If you have other health insurance Coverage besides Plan, it is important to use this other Coverage ***in combination with*** your Coverage as a Member to pay for the care you receive. This is called "coordination of benefits" because it involves ***coordinating*** all of the health ***benefits*** that are available to you. Using all of the Coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance Coverage besides Plan, and let us know whenever there are any ***changes*** in your additional insurance Coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for ***employees*** or ***Retirees***, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or Injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation Coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their Dependents keep their group health Coverage for a time after they leave their group health Plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance Coverage, how we coordinate your benefits as a Member of Plan with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through Plan, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Plan, you may get your care outside of Plan.

In general, the insurance company that pays its share of your bills *first* is called the **"primary payer."** Then the other company or companies that are involved -- called the **"secondary payers"** -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Customer Service at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called ***Medicare and Other Health Benefits: Your Guide to Who Pays First.*** You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

Subrogation and Reimbursement. A provision will apply that Plan receives all rights of recovery acquired by an enrollee against any person or organization for negligence or any willful act resulting in sickness or Injury covered by Plan benefits, but only to the extent of such benefits. Upon receiving such benefits from Plan, the enrollee is considered to have assigned such rights of recovery to Plan and to have agreed to give Plan any reasonable help required to secure the recovery. Plan will be entitled to recover reasonable attorney fees and court costs in connection with such recovery.

SECTION 12. Appeals and Grievances: what to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your Covered Services or the care you receive. Please call Customer Service at the number on the cover of this booklet.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a Plan Member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be Disenrolled from Plan or penalized in any way if you make a complaint.

What are Appeals and Grievances?

You have the right to make a complaint if you have concerns or problems related to your Coverage or care. "Appeals" and "Grievances" are the two different types of complaints you can make.

- An **"Appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.** For example, if we refuse to cover or pay for services you think we should cover, you can file an Appeal. If Texas HealthSpring or one of our Plan Providers refuses to give you a service you think should be covered, you can file an Appeal. If Texas HealthSpring or one of our Plan Providers reduces or cuts back on services you have been receiving, you can file an Appeal. If you think we are stopping your Coverage of a service too soon, you can file an Appeal.
- A **"Grievance"** is the type of complaint you make **if you have any other type of problem with Texas HealthSpring or one of our Plan Providers.** For example, you would file a Grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Making complaints (called "Appeals") about what we will cover for you or what we will pay for.** If Texas HealthSpring or your doctor or another Plan Provider has refused to give you a service you think is covered, you can make an Appeal. If we have refused to pay for a service you think is covered for you, you can make an Appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an Appeal. When you file an Appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).
2. **Making complaints (called "Appeals") if you think you are being discharged from the Hospital too soon.** There is a special type of Appeal that applies only to Hospital discharges. If you think our Coverage of your Hospital stay is ending too soon, you can Appeal directly and immediately to the Texas Medical Foundation, which is the Quality Improvement Organization in the state of Texas. Texas Medical Foundation is a group of health professionals in Texas that is paid to handle this type of Appeal

from Medicare patients. If you make this type of Appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of Appeal, and it will be decided quickly.

3. **Making complaints (called "Appeals") if you think your Coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.** There is another special type of Appeal that applies only to when Coverage will end for SNF, home health or comprehensive outpatient rehabilitation facility services. If you think your Coverage is ending too soon, you can Appeal directly and immediately to the Texas Medical Foundation, which is the Quality Improvement Organization in the state of Texas. If you make this type of Appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of Appeal, and it will be decided quickly.
4. **Making complaints (called "Grievances") about any other type of problem you have with Plan or one of our Plan Providers.** If you want to make a complaint about any type of problem other than those that are listed above, a Grievance is the type of complaint you would make. For example, you would file a Grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the Grievance with Texas HealthSpring. But for many problems related to quality of care you get from Plan Providers, you can also complain to the QIO in your state.

PART 1. Making complaints (called "Appeals") to Texas HealthSpring to change a decision about what we will cover for you or what we will pay for

This part of Section 12 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Plan.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Plan.
- If you are being told that Coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by Plan while you were a Member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from Plan

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail later in this section).

STEP 1: The initial decision by Texas HealthSpring

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for Members of Plan apply to your specific situation. As explained in this section, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Texas HealthSpring

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an **"Appeal"** or a "request for reconsideration." As explained in this section, you can ask for a "fast Appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your Appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Texas HealthSpring. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $100 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Medicare Appeals Council** to review your case. This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least $1,000 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, continue reading through this section.

PART 2. Making complaints if you think you are being discharged from the Hospital too soon

When you are hospitalized, you have the right to get all the Hospital care covered by Plan that is necessary to diagnose and treat your illness or Injury. The day you leave the Hospital (your "discharge date") is based on when your stay in the Hospital is no longer Medically Necessary. This section 12 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your Hospital stay

When you are admitted to the Hospital, someone at the Hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all Medically Necessary Hospital services covered.
- Your right to know about any decisions that the Hospital, your doctor, or anyone else makes about your Hospital stay and who will pay for it.
- That your doctor or the Hospital may arrange for services you will need after you leave the Hospital.

Review of your Hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask Texas HealthSpring to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your Hospital stay (stop paying our share of your Hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the Hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Texas HealthSpring or your Hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Texas, the QIO is called Texas Medical Foundation. The doctors and other health experts in Texas Medical Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the Coverage for their Hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your Hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the Texas Medical Foundation. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your Texas Medical Foundation and tells you what you must do.

- You must ask the Texas Medical Foundation for a **"fast review"** of whether you are ready to leave the Hospital. This "fast review" is also called a "fast Appeal" because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the Texas Medical Foundation **no later than noon** on the first working day after you are given written notice that you are being discharged from the Hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the Hospital past your discharge date without paying for it yourself, while you wait to get the decision from the Texas Medical Foundation (see below).

If the Texas Medical Foundation reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The Texas Medical Foundation will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the Texas Medical Foundation decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon of the calendar day after the Texas Medical Foundation gives you its decision.
- If the Texas Medical Foundation agrees with you, then we will continue to cover your Hospital stay for as long as Medically Necessary.

What if you do not ask the Texas Medical Foundation for a review by the deadline?

You still have another option: asking Texas HealthSpring for a "fast Appeal" of your discharge

If you do not ask the Texas Medical Foundation for a "fast review" ("fast Appeal") of your discharge by the deadline, you can ask us for a "fast Appeal" of your discharge. How to ask us for a fast Appeal is covered briefly in the first part of this section and in more detail in this section.

If you ask us for a fast Appeal of your discharge and you stay in the Hospital past your discharge date, you run the risk of having to pay for the Hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast Appeal, that you need to stay in the Hospital, we will continue to cover your Hospital care for as long as Medically Necessary.
- If we decide that you should not have stayed in the Hospital beyond your discharge date, then we will not cover any Hospital care you received if you stayed in the Hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can Appeal any bills for Hospital care you receive, using Step 1 of the Appeals process described in this section.

PART 3. Making complaints (appeals) if you think your Coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, Home Health Agency, or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, home health or CORF care covered by Plan that is necessary to diagnose and treat your illness or Injury. The day we end your SNF, Home Health Agency or CORF Coverage is based on when your stay is no longer Medically Necessary. This section explains what to do if you believe that your Coverage is ending too soon.

Information you will receive during your SNF, Home Health Agency or CORF stay

If we decide to end our Coverage for your SNF, home, health agency, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your Coverage ends. You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that Coverage should end – it only means that you received the notice.

How to appeal your Coverage to the Quality Improvement Organization

You have the right by law to ask for an Appeal of our termination of your Coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the "QIO") to do an independent review of whether our terminating your Coverage is medically appropriate.

How soon you have to ask the QIO to review your Coverage?

If you want to have the termination of your Coverage appealed, you must act quickly to contact the Texas Medical Foundation. The written notice you got from us or your provider gives the name and telephone number of the Texas Medical Foundation and tells you what you must do.

- You must be sure to make your request **no later than noon** of the day after you got the written notice from your provider.
- If you get the notice and you have more than 2 days before your Coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the Texas Medical Foundation reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your Coverage to be terminated on the date that has been set for you. The Texas Medical Foundation will make this decision within one full day after it receives the information it needs to make a decision.

- If the Texas Medical Foundation decides that the decision to terminate Coverage was medically appropriate, you will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice you got from your provider.
- If the Texas Medical Foundation agrees with you, then we will continue to cover your SNF, home health or CORF services for as long as Medically Necessary.

What if you do not ask the Texas Medical Foundation for a review in time? You still have another option: asking Texas HealthSpring for a "fast Appeal" of your discharge

If you do not ask the Texas Medical Foundation for a "fast Appeal" of your discharge by the deadline, you can ask us for a "fast Appeal" of your discharge. How to ask us for a fast Appeal is covered briefly in the first part of this section and in more detail in this section.

If you ask us for a fast Appeal of your termination and you continue getting services from the SNF, Home Health Agency, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast Appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as Medically Necessary.
- If we decide that you should not have continued getting Coverage for your care, then we will not cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the Texas Medical Foundation by noon after the day you are given written notice that we will be terminating Coverage for your SNF, home health or CORF services, and if you stay in the SNF, Home Health Agency or CORF after this date, you run the risk of having to pay for the SNF, home health or CORF care you receive on and after this date. However, you can Appeal any bills for SNF, home health or CORF care you receive using Step 1 of the Appeals process described in this section.

PART 4. Making complaints (called "Grievances") about any other type of problem you have with Plan or one of our Plan Providers

This last part of this section explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to Coverage or payment for care, and problems about being discharged from the Hospital too soon, and problems about coverage for Skilled Nursing Facility, Home Health Agency, or CORF services ending too soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a Hospital stay.
- If you feel that you are being encouraged to leave (Disenroll from) Plan.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or Hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a Grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision for appeal. See below for more detail.

Filing a Grievance with Plan

You should use Texas HealthSpring's Grievance process for complaints that do not involve Coverage issues as described above. If you have a complaint, we encourage you to first call Customer Service at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone and within 48 hours. If Customer Service is not able to resolve your concerns during your initial conversation, or within 48 hours, your complaint will be forwarded to the Solutions Unit.

We have a formal procedure to review your complaints. This type of formal complaint is processed by the Solutions Unit of Texas HealthSpring. Submit your formal Grievance in writing to the Solutions Unit and you will receive a response within 20 working days of Texas HealthSpring receiving your written concerns.

Please send all written Grievances to:

Texas HealthSpring
Attn: Solutions Unit
2900 North Loop West, Suite 1300
Houston TX 77092
832-553-3414 (fax)

If you have a question about what type of complaint process to use, please call our Customer Service department at the number on the cover of this document.

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a Hospital stay, you can also complain to an independent organization called the Texas Medical Foundation. See Section 1 for more information about the Texas Medical Foundation.

What are "complaints about your Coverage or payment for your care"?

Complaints about your Coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a Plan Member. This includes payment for care received while a Member of the Plan. Complaints about your Coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Plan
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Plan
- If you are being told that Coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by Plan, but we have refused to pay for this care because we say it is not covered

How does the Appeals process work?

The six possible steps you can take to make complaints related to your Coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the Appeals process:

- **Moving from one step to the next.** At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **"Initial decision" vs. "making an Appeal."** Step 1 deals with the starting point for the Appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "Appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.

- **Who makes the decision at each step.** In Step 1, you make your request for Coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you "Appeal" this initial decision (asking us to reconsider). **After Step 2, your Appeal goes outside of Texas HealthSpring, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your Appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: Texas HealthSpring makes an "initial decision" about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by Texas HealthSpring is the starting point for dealing with requests you may have about your Coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "Appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call Customer Service at the number on the cover of this booklet to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by Plan. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Texas HealthSpring, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call Customer Service at the number on the cover of this booklet to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for Members of Plan apply to your specific situation. This booklet and any Amendments you may receive describe the benefits and services covered by Plan, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Plan).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your ***authorized representative.*** You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at 2900 North Loop West, Solutions Unit, Suite 1300, Houston, TX 77092, or faxed to 832-553-3414. You can call Customer Service at the number on the cover of this booklet to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other Referral service. There are also groups that will give you free legal services if you qualify. You may want to contact the State Health Insurance Assistance Program at 1-800-252-9240.

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Texas HealthSpring, Solutions Unit, 2900 North Loop West, Suite 1300, Houston, TX 77092, or fax it to 832-553-3414.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling Customer Service at 832-553-3480 locally, 1-800-280-8888 toll-free, (for TTY, call 1-877-893-1504). Or, you can deliver a written request to Texas HealthSpring, Solutions Unit, 2900 North Loop West, Suite 1300, Houston, TX 77092, or fax it to 832-553-3414. Be sure to ask for a "fast" or "72-hour" review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your Medical Condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast Grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a decision about payment for care you already received.*
   - We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can Appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then Appeal this decision. (An Appeal is also called a reconsideration.) Step 2 tells how to file this Appeal.
2. *For a standard initial decision about medical care.*
   - We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to

gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "Grievance." This section of this booklet tells how to file a Grievance.

- We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to Appeal our decision. Step 2 tells how to file this Appeal.
- If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to Appeal. Step 2 tells how to file this Appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to Appeal.

3. *For a fast initial decision about medical care.*

- If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "Grievance." This section of this booklet tells how to file a Grievance.
- We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a Grievance. This section of this booklet tells how to file a Grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. *For a decision about payment for care you already received.*

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. *For a standard decision about medical care.*

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide ***completely*** or only ***partly*** against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you all that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "Appeal" or "request for reconsideration."

Please call Customer Service at the number on the cover of this booklet if you need help in filing your Appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your Appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your Appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" Appeal. The procedures for deciding on a "standard" or a "fast" ***Appeal*** are the same as those described for a "standard" or "fast" ***initial decision*** in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your Appeal

We must gather all the information we need to make a decision about your Appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your Appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to **Texas HealthSpring,**
  Solutions Unit
  2900 North Loop West, Suite 1300,
  Houston, TX 77092
- By fax, at 832-553-3414.
- By telephone -- if it is a "fast" Appeal -- at 832-553-3480.

You also have the right to ask us for a copy of information regarding your Appeal. You can call us at the number on the cover of this booklet, or write us at Texas HealthSpring, Solutions Unit, 2900 North Loop West, Suite 1300, Houston, TX 77092, or fax request to 832-553-3414. We are allowed to charge a fee for copying and sending this information to you.

How do you file your Appeal of the initial decision?

The rules about who may file an Appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision'" about medical care or payment?"

Either you, someone you appoint, or your provider may file this Appeal.

However, providers who do not have a contract with Texas HealthSpring must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the Appeal.

How soon must you file your Appeal?

The Appeal should be given to us in writing at Texas HealthSpring, Solutions Unit, 2900 North Loop West, Suite 1300, Houston, TX 77092, or fax to 832-553-3414, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your Appeal to your Social Security Administration office. Please note that sending your Appeal to this office instead of to us will cause a delay when we begin the Appeal, since this office must forward your Appeal request to us.

What if you want a "fast" Appeal?

The rules about asking for a "fast" Appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" Appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your Appeal?

How quickly we decide on your Appeal depends on the type of Appeal:

1. *For a decision about payment for care you already received.*

   After we receive your Appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your Appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   After we receive your Appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

   After we receive your Appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

   We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your Appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your Appeal. If we extend the time needed to decide your Appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your Appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your Appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your Appeal?

If we deny any part of your Appeal in Step 2, then your Appeal automatically goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Texas HealthSpring. We will tell you in writing that your Appeal has been sent to this organization for review. How quickly we must forward your Appeal to the independent review organization that performs the review in Step 3 depends on the type of Appeal:

1. *For a decision about payment for care you already received.*

   We must send all the information about your Appeal to the independent review organization within 60 calendar days from the date we received your Appeal in Step 2.

2. *For a standard decision about medical care.*

   We must send all of the information about your Appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your Appeal in Step 2.

3. *For a fast decision about medical care.*

   We must send all of the information about your Appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your Appeal in Step 2, your Appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your Appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your Appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your Appeal, how long the organization can take to make a decision depends on the type of Appeal:

1. *For an Appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.

2. *For a standard Appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.
3. *For a fast Appeal about medical care*, the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of Appeal:

1. *For an Appeal about payment for care,*
   We must pay within 30 calendar days after receiving the decision.
2. *For a standard Appeal about medical care,*
   We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.
3. *For a fast Appeal about medical care,*
   We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your Appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your Appeal is $100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your Appeal in Step 3. They will then send your request along with your Appeal information to the Administrative Law Judge who will hear your Appeal.
- To Texas HealthSpring, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your Appeal in Step 3. The independent review organization will then send your request along with your Appeal information to the Administrative Law Judge who will hear your Appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your Appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by counsel. The Administrative Law Judge will not review the Appeal if the dollar value of the medical care is less than $100. If the dollar value is less than $100, you may not Appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Texas HealthSpring may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,000 or more. If the dollar value is less than $1,000, you may not Appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to Appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,000. If the dollar value is less than $1,000, the Board's decision is final.

If the Council decides against you

If the amount involved is $1,000 or more, you or we have the right to continue your Appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,000, you may not take the Appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is $1,000 or more, you or we may ask a Federal Court Judge to review the case.

SECTION 13. Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of Texas may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care plans, like Texas HealthSpring, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

SECTION 14. Extra Programs & Services

What additional services or programs am I entitled to under the Plan? The following services are additional services that you are entitled to as a Member of the Plan.

Transportation

Attention Medicare Beneficiaries!

Texas HealthSpring has a Transportation benefit.

Does your current Medicare health plan provide a ride to the doctor's office?

Texas HealthSpring's Medicare HMO Plan covers rides to your doctor's office as well as many other benefits not covered by Original Medicare, all included in your monthly Plan Premium. See Section 7 for further details about the 30 annual transportation rides available to you under this benefit

Texas HealthSpring is pleased to offer Fresh Air Accessible Transportation as our provider for the transportation benefit for our Members.

This benefit provides up to 30 one-way trips to a medical provider each calendar year for a $0 Copayment. Each trip must begin and end within the Texas HealthSpring Service Area. You must call 1-888-318-6362, prior to 4:00 p.m. on the business day before your appointment to schedule your trip(s).

The hours of operation for this service are Monday through Saturday from 6:00 am to 10:00 pm, and Sunday from 8:00 am to 6:00 pm. A ride or trip is defined as transportation to one destination inside the Texas HealthSpring Service Area to receive medical services from Texas HealthSpring Network Providers, including dental providers.

A ride from your Texas HealthSpring healthcare provider back to your home would be counted as a second trip. If you want to stop at the pharmacy on the way home this is a third trip.

- **CALL 24 hours in advance to schedule your trip**
- **CALL 1-888-318-6362**
- **$0 Copayment each trip**
- **Monday through Friday 6:00 a.m. to 10:00 p.m.**
- **Saturday and Sunday 8:00 a.m. to 6:00 p.m.**

Q. What is meant by a "trip"

A. A 'trip' is one way, for example from your home to your doctor's office. If you need a return ride home that would be a second 'trip'. If you wanted to stop at the pharmacy on the way home that would also be counted as a 'trip'.

Q. How soon do I have to call to reserve my trip(s)?

A. You must call prior to 4:00 p.m. on the business day before your appointment to schedule your trip(s).

Q. What if I need a ride on a Saturday or Sunday?

A. The service is available 7 days per week. Monday through Friday hours are 6:00 am to 10:00 pm. Saturday and Sunday hours are 8:00 am to 6:00 pm.

Q. What if my spouse (daughter, son, friend, companion) wants to go to the doctor's office with me?

A. You may have a Child, spouse, or friend accompany you at no additional Copayment. When you call to schedule your ride(s) just tell them that someone will be accompanying you. If you have any special medical needs, please advise Fresh Air when you make your reservation.

SilverSneakers Fitness Program

Attention Medicare Beneficiaries!

Texas HealthSpring has a Fitness Center benefit called SilverSneakers at no additional cost to the Member!!!

This fitness program is a unique exercise and socially oriented program designed to encourage you to increase your level of physical activity in a fun social environment.

All Members will receive a SilverSneakers enrollment packet when they join the Plan. This packet describes all the services available as a participant in SilverSneakers. Once enrolled you will have access to a number of leading fitness centers throughout the Plan's Service Area where you may participate in fitness and social activities designed to improve your health and provide a fun environment for physical activity. All fitness classes are geared towards the needs of seniors and are supervised by a Silver Sneakers trained individual. Your Texas HealthSpring ID card will act as your membership card at affiliated Silver Sneakers facilities.

It is recommended that prior to beginning a fitness program through SilverSneakers that you consult with your Primary Care Physician.

As additional service, benefits or value added options become available Texas HealthSpring will notify you to enable you to take full advantage of all your opportunities with the Plan.