

**SelectCare of Texas, LLC**

**4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

**1-866-230-2513 or TTY for the hearing impaired: 1-888-685-8480**

**CITY OF HOUSTON**

**TEXANPLUS  
GREATER HOUSTON METROPOLITAN AREA**

**MEDICARE ADVANTAGE  
2005 MEMBER EVIDENCE OF COVERAGE**

## IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact SELECTCARE at 1-866-230-2513 between the hours of 8:00 am and 5:00 pm CDT.

You may call SELECTCARE's toll-free telephone number, between the hours of 8:00 am and 5:00 pm CDT, for information or to make a complaint at:

SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081

**1-866-230-2513**

You may also write to the TEXANPLUS Plan at:

SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081

You may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at

**1-800-252-3439**

You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX #(512) 475-1771

### **PREMIUM OR CLAIM DISPUTES:**

Should You have a dispute concerning your Premium or about a claim You should contact SELECTCARE first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

## AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con SELECTCARE a 1-866-230-2513 entre las horas de 8:00 am y 5:00 pm CDT.

Usted puede llamar al numero de telefono gratis, entre las horas de 8:00 am y 5:00 pm CDT, de SELECTCARE para informacion o para someter una queja al:

SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081

**1-866-230-2513**

Usted tambien puede escribir al TEXANPLUS Plan:

SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX #(512) 475-1771

### **DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concierne a su prima o a un reclamo, debe comunicarse con SELECTCARE primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

**NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER  
TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC  
HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR  
PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT  
A GENERAL HOSPITAL, CALL:  
1-800-538-6467**

Your complaint will be referred to the state agency that regulates the Hospital or chemical dependency treatment center.

**AVISO DE NUMERO TELEFONICO ESPECIAL GRATIS PARA QUEJAS  
PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL  
PSIQUIATRICO PRIVADO, CENTRO DE TRATAMIENTO PARA LA  
DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS  
O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL,  
LLAME A:  
1-800-538-6467**

Su queja sera referida a la agencia estatal que regula el Hospital o centro de tratamiento para la dependencia quimica.

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**TEXANPLUS**

**MEDICARE ADVANTAGE  
2005 MEMBER EVIDENCE OF COVERAGE**

**SECTION 1  
INTRODUCTION AND GENERAL INFORMATION**

SelectCare of Texas, LLC (“SELECTCARE”) (a **Medicare Advantage Organization**), with a Medicare contract, has agreed to offer TEXANPLUS (a **Medicare Advantage Plan**) to Medicare Advantage eligible individuals in the Service Area. Medicare Advantage is the new name for Medicare+Choice.

This Evidence of Coverage (EOC) sets forth your rights and obligations. It is important that You **READ YOUR EOC CAREFULLY** and familiarize yourself with its terms and conditions.

If You need to receive this booklet in a different format (such as a Spanish translation) please call SELECTCARE so SELECTCARE can send You a copy. Contact your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480.

This document specifies the Covered Health Services which You as a Member are entitled to receive under this **Group Medicare Advantage Plan** in consideration of continued enrollment in Medicare Parts A and B, and payment of any required TEXANPLUS Premiums.

Coverage under this EOC will take effect on the date specified after SELECTCARE determines that You are eligible for Coverage and receives notice from the Centers for Medicare & Medicaid Services (CMS) the federal agency responsible for administering Medicare, that You are entitled to Medicare Advantage benefits. All Coverage under this EOC will begin at 12:01 a.m. local time on the CMS confirmed Effective Date and will end at 12:00 midnight local time on the date of disenrollment.

This EOC is issued for an initial term that begins on your Effective Date and ends on December 31 of the last year of the agreement between SelectCare and your Employer, unless sooner terminated in accordance with such Agreement. For rules governing the effective date of enrollments and disenrollments included under this EOC, see Section 3.3 and Section 4. You may continue Coverage in the next calendar year under a revised EOC by continued enrollment in Medicare Parts A and B, payment of the Medicare Part B Premium, and any required Employer Premium.

This EOC is delivered in and governed by the laws of the State of Texas, to the extent not preempted by federal law, and of the United States Government. SELECTCARE does not discriminate in the employment of staff or in the provision of health care Coverage on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin. Federal law mandates that SELECTCARE comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination In Employment Act of 1975, the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, other laws applicable to recipients of federal funds, and all other applicable laws and rules. 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 EOC. The principal law that applies to this EOC 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 of Texas may apply. SELECTCARE acknowledges that required Medicare services include CMS's national coverage decisions (NCDs), local medical review policies (LMRPs), and published coverage decisions of local carriers and intermediaries specific to the geographic area in which services are covered under this Medicare Advantage Plan.

## **Contacting SELECTCARE**

Throughout this EOC You will find statements that encourage You to contact SELECTCARE for further information. Whenever You have a question or concern regarding the Covered Health Services under TEXANPLUS, a provider's Contracted status or any required procedure, please contact your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480.

## **Coverage Rules**

Under a contract with CMS, SELECTCARE agrees to provide all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare as described in this document.

The Covered Health Services described in this EOC, including Medicare covered services, are Covered Health Services only if they are ordered, arranged, or provided by or under the direction of your Primary Care Physician You select from the Directory of Physicians and Health Care Providers, except for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services, Urgently Needed Health Services and non-referral Covered Health Services as described in Sections 6 and 7 of this EOC. If You receive health services from a Non-Contracted Physician or other Non-Contracted provider without following SELECTCARE's Coverage Rules, neither SELECTCARE, your Employer, nor CMS will pay the charges. You will be responsible for the cost of those health services.

Coverage under TEXANPLUS is subject to the terms, conditions, limitations, and exclusions of this EOC and is also subject to federal legislative changes under Title XVIII, Health Insurance for the Aged and Disabled, of the United States Social Security Act. Coverage is also subject to payment of the Medicare Part B Premium and any required TEXANPLUS Premium. You have an obligation to pay applicable Copayments and Coinsurance amounts under this EOC.

SELECTCARE will be responsible for interpreting Covered Health Services provided under this EOC. SELECTCARE may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to this EOC.

If You disenroll from TEXANPLUS and then seek reinstatement with TEXANPLUS before the end of the calendar year in which You disenrolled, any benefit that You received before You disenrolled continues to apply toward any days, month, annual, lifetime, or dollar benefit limits or other service limits and will be carried forward into your reinstatement with TEXANPLUS for that contract period. If You receive any benefit before You disenrolled that is a multiyear benefit, any benefit received will be carried forward until the end of the multiyear Benefit Period. Multiyear benefits (if applicable) may not be available in subsequent years.

The above conditions are referred to as SELECTCARE's **Coverage Rules** throughout this EOC.

### **How to Use This EOC**

This EOC should be read and re-read in its entirety. Many of the provisions of this EOC are interrelated; therefore, reading just one or two provisions may not give You an accurate impression of your Coverage.

Many words used in this EOC have special meanings. These words will appear capitalized and are defined in Section 2 of this document. By reviewing these definitions, You will have a clearer understanding of your EOC.

From time to time, this EOC may be amended by SELECTCARE and your Employer. When that happens, a new EOC or Amendment page(s) for this EOC will be sent to You. Your EOC should be kept in a safe place for your future reference.

### **General Information**

If a Physician or other health care professional refuses to provide treatment (including counseling or referral services) on religious or moral grounds, SELECTCARE will assist You in finding another Physician or provider.

Only Covered Health Services (as defined in Section 2) are covered under this EOC. An example of a non-covered service is any service that is Experimental, Investigational or Unproven.

SELECTCARE may, in certain circumstances for purposes of overall cost savings or efficiency and in SELECTCARE's sole discretion, provide Coverage for services that would otherwise not be Covered Health Services. The fact that SELECTCARE does so in any particular case will not in any way be deemed to require SELECTCARE to do so in other similar or dissimilar cases.

SELECTCARE may, at its sole discretion, arrange for various persons or entities to provide administrative services on its behalf, such as claims processing and utilization management services. The identity of these service providers and the nature of the services they provide may be changed from time to time in SELECTCARE's sole discretion. SELECTCARE is not required to give You prior notice of any such change, nor is SELECTCARE required to obtain your

approval. It is important that You cooperate with those persons or entities in the performance of their responsibilities.

If Physicians or certain other providers enter into a written private contract with any Medicare beneficiary to provide services that would otherwise be covered by Medicare, that provider has, in effect, opted out of Medicare. Under such circumstances, any services that would normally be covered by Medicare will no longer be covered by Medicare and are not Covered Health Services under this EOC. Exceptions to this requirement is Emergency Health Services and Urgently Needed Health Services provided by such providers.

If You temporarily reside outside the Service Area (less than 6 consecutive months), You are only covered for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services and Urgently Needed Health Services while outside of the Service Area.

No person has authority to make any oral changes or Amendments to this EOC.

### **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 SELECTCARE) 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 SELECTCARE and continue to get the rest of your care that is unrelated to the clinical trial through SELECTCARE. 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, **24 hours a day/7 days a week** (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web. This 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 Medicare Advantage Plan provider to join a clinical trial, and the clinical trial providers do not need to be Medicare Advantage Plan providers. However, please be sure to **tell SELECTCARE before You start a clinical trial** so that SELECTCARE can keep track of your health care services. When You tell SELECTCARE about starting a clinical trial, SELECTCARE 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 SELECTCARE under certain conditions. Covered Health Services in a RNHCI are limited to non-religious aspects of care. To be eligible for Covered Health 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 RNHCIs. 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 SELECTCARE, or your stay in the RNHCI may not be covered.

## **Identification Card**

You must show your TEXANPLUS identification card (TEXANPLUS ID) every time You request Covered Health Services. If You do not show your TEXANPLUS ID, the provider will not know that You are covered by TEXANPLUS and You may receive a bill for Covered Health Services or be required to pay at the time Covered Health Services are received.

Do not use your Medicare card to access health services while You are enrolled in TEXANPLUS. Your Medicare card will not identify that You have selected TEXANPLUS to administer all your Medicare covered benefits. Therefore, claims submitted to Medicare, rather than to SELECTCARE, for Covered Health Services provided to You under TEXANPLUS during the time this EOC is in force, will be denied payment by Medicare.

Possession and use of the TEXANPLUS ID does not grant entitlement to Coverage. Coverage is subject to verification of eligibility and is also subject to all terms, conditions, limitations, and exclusions of this EOC.

Please help SELECTCARE keep your membership record up to date by letting your Personal Service Specialist 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 your Personal Service Specialist about any changes in health insurance coverage You have from other sources, such as from your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident.

## **Paying your share of the cost when You get covered services**

### **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, as shown in Section 7. You pay it when You get the service. The benefits chart in this Section 1 gives your Copayments for Covered Health Services.

A “Coinsurance” is a payment You make for your share of the cost of certain Covered Health Services You receive. Coinsurance is a percentage of the cost of the service. You pay your Coinsurance when You get the service. The benefits chart in this Section 1 gives your Coinsurance for Covered Health Services.

## **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 TEXANPLUS. Other sections of this EOC tell about Covered Health Services and the rules that apply to getting your care as a TEXANPLUS Plan Member. With few exceptions, You must pay for services You receive from providers who are not part of SELECTCARE and TEXANPLUS unless SELECTCARE has approved these services in advance. The exceptions are care for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services, Urgently Needed Health Services and services that are found upon appeal to be services that SELECTCARE should have paid or covered.

For Covered Health Services that have a benefit limitation, such as the Outpatient Prescription Drug benefit **You must pay the full cost of any services You get after You have used up your benefit for that type of Covered Health Service.** You can call your Personal Services Specialist when You want to know how much of your benefit limit You have already used.

## **YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER OF SELECTCARE**

### **Introduction About Your Rights and Protections**

As a person with Medicare, You have certain rights to help protect You. In this EOC, SELECTCARE explains some of your Medicare rights and protections as a Member of TEXANPLUS. This EOC also tells what You can do if You think You are being treated unfairly or your rights are not being respected.

### **Your Right to be Treated with Fairness and Respect**

You have the right to be treated with dignity, respect, and fairness at all times. SELECTCARE must obey laws against discrimination that protect You from unfair treatment. These laws say that SELECTCARE cannot discriminate against You (treat You unfairly) because of your race or color, your age, your religion, the country You are from, or any mental or physical disability You may have. If You need help with communication, such as help from a language interpreter, please call your Personal Service Specialist at the number on the cover of this booklet. Your Personal Service Specialist can also help if physical barriers such as steps or curbs are a problem, and You need help with access (such as wheel chair access).

### **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. SELECTCARE keeps your personal health information private as protected under these laws. Any personal information that You give SELECTCARE when You enroll in the TEXANPLUS Plan is protected. SELECTCARE will make sure that unauthorized people do not see or change your records. Generally, SELECTCARE must get written permission from You (or from someone You have given legal power to make decisions for You) before SELECTCARE can give your health information to anyone who is not providing your care or paying for your care. There are a few 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. SELECTCARE is required to provide You with a notice that tells about these rights and explains how SELECTCARE protects 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 SELECTCARE to make additions or corrections to your medical records (if You ask SELECTCARE to do this, SELECTCARE 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. You also have the right to ask SELECTCARE to limit how your health information can be given out and used. If You have questions or concerns about privacy of your personal information and medical records, please call your Personal Service Specialist at the phone number on the cover of this booklet.

### **Your Right to See TEXANPLUS Plan Providers and Get Covered Services Within a Reasonable Period of Time**

As explained in this EOC, You will get all (or most) of your care from TEXANPLUS Plan providers, that is, from Physicians and other health providers who are part of TEXANPLUS. You have the right to choose a TEXANPLUS Plan provider (SELECTCARE will tell You which Physicians are accepting new patients). If You get services from any doctor, Hospital, or other health care provider without getting a referral in advance from your Primary Care Physician (PCP), You may have to pay for these services yourself – even if You get the services from a TEXANPLUS 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-refer” when You get these services on your own. You still have to pay your Copayment for these services.

- Routine woman’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 TEXANPLUS Plan provider.
- Flu shots and pneumonia vaccinations (as long as You get them from a TEXANPLUS Plan provider).
- Emergency Health Services, whether You get these services from TEXANPLUS Plan providers or non-TEXANPLUS Plan providers.
- Urgently Needed Health Services that You get from non-TEXANPLUS Plan providers when You are temporarily outside the TEXANPLUS Plan Service Area. Also, Urgently Needed Health services that You get from non-TEXANPLUS Plan providers when You are in the Service Area but, because of unusual or extraordinary circumstances, the TEXANPLUS Plan providers are temporarily unavailable or inaccessible.
- Renal dialysis (kidney) services that You get when You are temporarily outside the TEXANPLUS Plan Service Area. If possible, please let SELECTCARE know before You leave the Service Area where You are going to be so SELECTCARE can help arrange for You to have maintenance dialysis while outside the Service Area.

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 6.3 explains how to select a Primary Care Physician to get the care and services You need. Section 6.7 explains your right to get Emergency Health Services and Section 6.8 explains Urgently Needed Health Services.

### **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 TEXANPLUS. The Medicare program does not allow any rules that could keep your Physicians from telling You what You need to know about your treatment choices. 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, Investigational, or Unproven Procedures.

You have the right to receive a detailed explanation from SELECTCARE if You believe that a TEXANPLUS 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 11.

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 complete responsibility for what happens and any negative consequences as a result of You refusing treatment.

If your Contracted Physician, other Contracted provider, or SELECTCARE ever refuses to give You the health care, treatment, or services that You think You need, You have the right to get a written explanation that tells You why. You may be given a reminder entitled “MEDICARE DECISIONS AND YOUR RIGHTS” that explains some of your guaranteed rights and protections You have as a person with Medicare.

### **Using 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 Physicians 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 do 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, and from some office supply stores. You can sometimes get Advance Directive forms from organizations that give people information about Medicare. In Texas, this organization is called **Health Information Counseling & Advocacy Program (HICAP)**. The telephone number for HICAP is 1-800-252-9240. 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 Physician 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's 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 You have signed an Advance Directive or not. If You have signed an Advance Directive, and You believe that a Physician or Hospital has not followed the instructions in it, You may file a complaint with the Texas Department of Insurance by calling 1-800-252-3439.

## **Your Rights as a Hospital Patient**

In the event that You are hospitalized, someone at SELECTCARE or the Hospital is supposed to give You a document called "**Important Message from Medicare**". This message from the Medicare program explains your rights as a Hospital patient. These include the right to get all of the Hospital care You need that is covered by Medicare. You also have the right to be told why You are being discharged (released from the Hospital). The "**Important Message from Medicare**" tells what You can do if You think Coverage of your Hospital stay is ending too soon. See Section 11 for more information about this.

## **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 the situation:

- An **appeal** is a special kind of complaint You can make if SELECTCARE refuses to cover something You think is covered for You. If You have a complaint about health services that are not paid for, or not allowed, or stopped too soon, You can file an appeal. Section 11 tells about the special process You must use to make an appeal.
- A **grievance** is the type of complaint You make if You have problems with the way care is being given. This includes problems with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your Physicians or others behave, being able to reach someone by phone or get the information You need, or the

cleanliness or condition of the Physician's office. Section 11 explains how to file a grievance.

If You make a complaint, SELECTCARE must be fair in how it is handled. SELECTCARE must not treat You unfairly (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 SELECTCARE in the past. To get this information, call your Personal Service Specialist at the phone number on the cover of this booklet. Appeals and grievances are explained further in Section 11 of this EOC.

### **Your Right to Get Information About Your Health Care Coverage and Costs**

This EOC tells You what medical services are covered for You as a Member of TEXANPLUS and what You have to pay. If You need more information, please call your Personal Service Specialist at the number on the cover of this booklet. You have the right to an explanation from SELECTCARE about any bills You may get for services not covered by TEXANPLUS. SELECTCARE must tell You in writing why SELECTCARE will not pay for or allow You to get a service, and how You can file an appeal to ask SELECTCARE to change this decision. See Section 11 for more discussion of appeals.

### **Your Right to Get Information About SELECTCARE, TEXANPLUS, and TEXANPLUS Plan Providers**

You have the right to get information from SELECTCARE about SELECTCARE and TEXANPLUS. This includes information about SELECTCARE's financial condition, about the health providers and their qualifications, and about how TEXANPLUS compares to other health plans. You have the right to find out how SELECTCARE pays our Physicians. To get any of this information, call your Personal Service Specialist 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 your Personal Service Specialist at the number on the cover of this booklet. You can also get free help and information from the Health Information Conseling & Advancy Program (HICAP) at 1-800-252-9240. In addition, the Medicare program has written a booklet called **Your Medicare Rights and Protections**. To get a free copy, call 1-800-MEDICARE, **24 hours a day/7 days a week** (1-800-633-4227). Or You can visit the Medicare website at [www.medicare.gov](http://www.medicare.gov) to order this booklet or print it directly from your computer.

### **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 any of the following state agencies:

- Social Security Administration at 1-800-772-1213 (the TTY number is 1-800-325-0778);
- Texas Department of Human Services at 1-888-834-7406; or
- Area Agency on Aging at 1-800-252-9240.

**Texas Department of Aging (TDoA)** – TDoA is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. TDoA can explain your Medicare rights and protections, help You make complaints about care or treatment, and help straighten out problems with Medicare bills. TDoA has information about Medicare Advantage 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 SELECTCARE) for the first time. (Section 4 has more information about your Medigap guaranteed issue rights).

You can contact TDoA at 1-800-252-9240 or by mail at P.O. Box 12786, Austin, Texas 78711. You can also find the website for TDoA at [www.medicare.gov](http://www.medicare.gov) or [www.tdoa.state.tx.us](http://www.tdoa.state.tx.us) on the web.

### **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](http://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](http://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 (“Employer”), call your employer's benefits administrator at 713-837-9400 or your Personal Service Specialist at the phone number on the cover of this booklet if You have any questions about your benefits, TEXANPLUS Premiums, or the open enrollment season.

### **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 the situation:

- If You think You have been treated unfairly due to your race, color, national origin, disability, age, or religion, call the Office for Civil Rights (OCR) in your area. The OCR office for Texas is located at:

**U.S. Department of Education Office for Civil Rights  
1999 Bryan Street, Suite 2600  
Dallas, Texas 75201**

**Telephone: 1-214-880-2459  
Email: [OCR.Dallas@ed.gov](mailto:OCR.Dallas@ed.gov)**

- For any other kind of concern or problem related to your Medicare rights and protections described in this Section, You can call your Personal Service Specialist at the number on the cover of this booklet. You can also get help from the Health Information Counseling & Advocacy Program (HICAP) at 1-800-252-9240.

### **What Are Your Responsibilities as a Member of TEXANPLUS?**

Along with the rights You have as a Member of TEXANPLUS, You also have some responsibilities. Your responsibilities include, but are not limited to, the following:

- To get familiar with your Coverage and the rules You must follow to get care as a Member of TEXANPLUS. You can use this booklet and other information SELECTCARE give You to learn about your Coverage, what You have to pay, and the rules You need to follow. Please call your Personal Service Specialist at the telephone number on the cover of this booklet if You have any questions.
- To give your Physician and other providers the information they need to care for You and to follow the treatment plans and instructions that You and your Physicians agree upon. Be sure to ask your Physicians 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 Physician's office, Hospitals, and other offices.
- To pay your TEXANPLUS Plan Premiums (if applicable) and any Copayments and Coinsurance amounts You may owe for the Covered Health Services You get. You must also meet your other financial responsibilities that are described in this EOC.
- To let SELECTCARE know if You have any questions, concerns, problems or suggestions. If You do, please call your Personal Service Specialist at the phone number on the cover of this booklet.



## SECTION 2 DEFINITIONS

This Section defines the capitalized terms used throughout this EOC and is not intended to describe Covered or non-Covered services.

**“Alternate Facility”** - a non-Hospital health care facility, or an attached facility designated as such by a Hospital to provide one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received: outpatient surgical services, Emergency Health Services, Urgently Needed Health Services, post-stabilization care, renal dialysis, rehabilitative, laboratory or diagnostic services, or outpatient Mental Health Services, or Substance Abuse Services.

**“Alternative Health Benefits Plan”** – means any health benefit plan, other than the TEXANPLUS Plan, that is offered by the City of Houston.

**“Amendment”** - an attached description of additional or alternative provisions of this EOC. Amendments are effective only when signed by SELECTCARE 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.

**“Annual Out-of-Pocket Maximum”** – is the maximum annual out-of-pocket cost You pay for Copayments and Coinsurance for specified services as further described in Section 7.29.

**“Application”** – means the forms prescribed by SELECTCARE 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 SELECTCARE for the purpose of enrolling for Coverage in the TEXANPLUS Plan.

**“Basic Benefit Package”** - all health services that are covered under the Medicare Part A program and Part B program, additional services (benefits funded from excess amounts SELECTCARE receives from CMS minus what SELECTCARE spends for all services and expenses), and mandatory supplemental services (benefits SELECTCARE has agreed to provide for Medicare Advantage enrollees beyond what Medicare alone would provide), except hospice services.

**“Benefit Period”** - a period of consecutive days which begins with a Confinement in a Hospital (including a psychiatric Hospital), Skilled Nursing Facility or Inpatient Rehabilitation Facility in which You receive inpatient health services and ends when You have not been Confined in the Hospital (including a psychiatric Hospital), Skilled Nursing Facility or Inpatient Rehabilitation Facility for a period of 60 consecutive days.

**“Brand-name Formulary”** - a Prescription Drug Product that is: (i) (a) manufactured and marketed under a trademark or name by a specific manufacturer; or (b) identified as a Brand-name product by SELECTCARE or its designee based on a pharmaceutical price indicator; and (ii) on the SELECTCARE Formulary.

**“Brand-name Non-Formulary”** - a Prescription Drug Product that is : (i) (a) manufactured and marketed under a trademark or name by a specific manufacturer; or (b) identified as a Brand-

name product by SELECTCARE or its designee based on a pharmaceutical price indicator; and (ii) not on the SELECTCARE Formulary.

**“Centers for Medicare and Medicaid Services” or “CMS”** - shall mean the administrative agency of the U.S. Government responsible for administering the Medicare program. CMS is formerly known as the Health Care Financing Administration (HCFA).

**“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”** – the charge, in addition to any applicable Premium, that You are required to pay for certain Covered Health Services provided under this EOC. A Coinsurance will be generally stated as a percentage of Eligible Expenses. For a Contracted provider, the percentage is based on the contracted charge, or if none, the Medicare Allowable Charge. However, if a Contracted provider is paid for a Covered Health Service on a capitated or global fee basis, Coinsurance will be a percentage of the Medicare Allowable Charge for the service. If there is no Medicare Allowable Charge for a Covered Health Service, then the Coinsurance will be a percentage of the reasonable and customary fee for the service as determined by SELECTCARE. For Non-Contracted providers, the percentage is based on the lesser of the Medicare Allowable Charge or the provider’s billed charges. You are responsible for the payment of any Coinsurance directly to the provider of the Covered Health Services at the time of service or when billed by the provider.

**“Confinement”** and **“Confined”** - an uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**“Contracted”** - used to describe a provider of health services (such as a Hospital, Physician, Dentist, Alternate Facility, Home Health Agency, pharmacy, Skilled Nursing Facility, Mental Health/Substance Abuse Designee, Inpatient Rehabilitation Facility or Urgent Care Center) that has the required Medicare certification and has entered into a written agreement with SELECTCARE to provide Covered Health Services to TEXANPLUS Members. The Contracted status of particular providers may change from time to time.

**“Contracted Rate”** – the amount SELECTCARE pays to a Contracted pharmacy for Prescription Drug Products including any applicable tax and applicable dispensing fees.

**“Copayment”** - the charge, in addition to any applicable Premium, which You are required to pay directly to the provider of the Covered Health Services at the time of service or when billed by the provider for certain Covered Health Services provided under this EOC. A Copayment will be stated as a dollar amount.

**"Cosmetic Procedures"** - procedures and services that change or improve physical appearance and do not significantly improve physiological functioning as determined by SELECTCARE.

**"Coverage"** - entitlement to payment of Covered Health Services available under this EOC, subject to the terms, conditions, limitations and exclusions of this EOC.

**"Covered Health Services"** - those health services and supplies provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse or their symptoms for which SELECTCARE is obligated or has agreed to pay. Covered Health Services must be provided: (a) while this EOC is in effect; (b) prior to the date that any of the disenrollment conditions of Section 4 occur; and (c) only while You are a Member and meet all eligibility requirements specified in this EOC.

A Covered Health Service must meet each of the following criteria:

- A. It is supported by national medical standards of practice; and
- B. It is consistent with conclusions of prevailing medical research that:
  - 1. Demonstrates that the health service has a beneficial effect on health outcomes; and
  - 2. Is based on trials that meet the following designs:
    - a. Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.); or
    - b. Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.); and
- C. It is a cost-effective method and yields a similar outcome to other available alternatives; and
- D. It is a health service described in Section 7 and is not excluded under Section 8.

The decisions to cover new technologies, procedures and treatments are made based on the language above.

**"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 TEXANPLUS nor covered by Medicare unless in conjunction with Skilled Care Services and/or services provided at an Inpatient Rehabilitation Facility.

**"Deferred Retired Employee"** means an individual who meets the Subscriber eligibility requirements set forth in Section 3 of this Evidence of Coverage, who was an employee of the City of Houston and as a member of one of the state statutory pension plans that are offered to the City of Houston's employees:

1. 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
2. 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 City of Houston.

**"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 TEXANPLUS Plan, for whom the Premium payments required hereunder have been received by SELECTCARE in accordance with the terms of this EOC and who continues to meet the eligibility requirements set forth in this EOC.

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

**"Durable Medical Equipment"** - medical equipment which: (a) can withstand repeated use and is not disposable; (b) is used to serve a medical purpose; (c) is generally not useful to a person in the absence of a Sickness or Injury; (d) is appropriate for use in the home; and (e) is prescribed by a Physician.

**"Eligible Dependent"** means an Eligible Employee's spouse or Child who meets the Dependent eligibility requirements set forth in this Evidence of Coverage.

**"Eligible Employee"** means an individual who meets the Subscriber eligibility requirements set forth in this Evidence of Coverage.

**"Eligible Expenses"** - fees for Covered Health 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 Health Services provided through a referral. All Eligible Expenses must be Covered Health Services under this EOC and incurred while this EOC is in effect.

**"Emergency"** - those situations when a Medical Condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of

immediate medical attention to result in: (a) placing the health of the individual (or, with respect to pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. In an Emergency, do not wait to determine if a provider is Contracted with SELECTCARE. See Section 6.7 for details.

**“Emergency Health Services”** - Covered inpatient or outpatient services, furnished by a provider qualified to furnish Emergency Health Services, for stabilization or initiation of treatment for Emergency conditions provided by a Contracted or non-Contracted Physician or other Contracted or non-Contracted provider, **generally at a Hospital emergency room**, in or out of the Service Area.

**"Evidence of Coverage" or “EOC”** – means this document, along with your Application or other enrollment forms, which explains the Covered Services, defines SELECTCARE’s obligations, and explains your rights and responsibilities as a Member of the TEXANPLUS 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 SELECTCARE (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. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. a service that does not meet the definition of a Covered Health 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), SELECTCARE may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to occur, SELECTCARE 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 SELECTCARE to approve and/or pay for any Experimental, Investigational, or Unproven Procedures unless SELECTCARE approves the Experimental, Investigational, or Unproven Procedure(s) in writing in advance of such Experimental, Investigational, or Unproven 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 the TEXANPLUS Plan or an Alternative Health Benefits Plan.

**"Formulary"** means the list of outpatient prescription drugs covered under the TEXANPLUS 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 SELECTCARE or SELECTCARE'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 SELECTCARE.

**"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 Resolution Process"** – a process to address any complaint or concern regarding provisions of Covered Health Services or benefits under this EOC that is not subject to the Medicare Appeals Process (see Section 11). Grievances are subject to the Grievance Resolution Process (see Section 11).

**"Group"** – means the City of Houston. Group may also be referred to as "Employer."

**"Health Professional"** means Dentist, nurse, audiologist, podiatrist, osteopath, optometrist, Physician's assistant, nurse first assistants, acupuncturists, clinical psychologist, social worker, pharmacist, nutritionist, physical therapist, speech therapist or other professional engaged in the delivery of health services who is licensed, practices under an institutional license, is certified or practices under the authority of a Physician or legally constituted professional association or other authority consistent with the laws of the State of Texas.

**"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 Health 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”** means any physical or mental condition, including without limitation a condition that results from illness, Injury (accidental or non-accidental) Pregnancy or congenital malformation.

**“Medically Necessary”** or **“Medical Necessity”** means those health care services provided to a Member that are (i) appropriate and necessary for the symptoms, diagnosis, or treatment of the Member’s Medical Condition; (ii) provided for the diagnosis or direct care and treatment of the Member’s Medical Condition; (iii) within standards of good medical practice established by the organized medical community; (iv) not primarily for the convenience of the Member or a Provider; and (v) provided at an appropriate supply or level of service needed to provide safe and adequate care. The final determination of whether a service, supply or benefit was Medically Necessary shall be made by SelectCare or its designee, subject to appeal under the applicable grievance and appeals procedures.

**“Medicare”** – Parts A and B of the insurance program established by Title XVIII, Health Insurance for the Aged and Disabled, of the United States Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended.

**“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 Health Services or reimbursement of a claim (see Section 11).

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

**“Medicare Advantage Plan”** -- a Basic 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 Medicare Advantage Plan. A Medicare Advantage Organization may offer more than one Medicare Advantage Plan in the same Service Area. TEXANPLUS is a Medicare Advantage Plan.

**“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.

**“Member”** means any Eligible Employee who meets the Member eligibility requirements set forth in Section 3 of this Evidence of Coverage, who has retired from the service of the City of Houston, and who has enrolled in the TEXANPLUS Plan and for whom the Premium payments required under the Agreement have been received by SELECTCARE in accordance with the terms of the Agreement. “You” and “your” refer to the Member in this Evidence of Coverage and where applicable, the Member’s duly authorized representative. For purposes of the Agreement, Member shall also include the spouse or dependant of an Eligible Employee so long as they otherwise meet the eligibility requirements as described in Section 3 of this Evidence of Coverage.

**“Mental Health Services”** – Covered Health 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 Health Service. Only Mental Health Services covered under Medicare are Covered Health 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-Contracted”** - used to describe a provider of health services (such as a Hospital, Physician, Dentist, Alternate Facility, Home Health Agency, Skilled Nursing Facility, or Urgent Care Center) and means that the provider has not entered into a written agreement with SELECTCARE to provide Covered Health Services under this EOC.

**“Original Medicare”** – A plan that is available everywhere in the United States that is funded by the United States government. 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 per-per-visit program that lets You go to any doctor, Hospital, or other Health Professional 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).

**“Organization Determination”** - a decision by SELECTCARE or its designees concerning your request for Coverage of, or payment of a claim for, Covered Health Services.

**“Physician”** - a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of the jurisdiction in which treatment is received.



**"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.

**"Pregnancy"** - includes prenatal and postnatal care, childbirth, early termination of Pregnancy, and any complications associated with Pregnancy.

**"Premium"** - the periodic fee required from You and paid to SELECTCARE 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.

**"Prescription Drug Product"** - a medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill.

**"Prescription Drug Product Prior Approval"** - the process of obtaining approval for certain Prescription Drug Products, prior to dispensing, using guidelines approved by SELECTCARE. This approval is to be obtained from SELECTCARE or its designee by the prescribing Physician or the pharmacist. The list of Prescription Drug Products requiring prior approval is subject to periodic review and modification by SELECTCARE.

**"Prescription Order or Refill"** - the directive to dispense a Prescription Drug Product issued by a provider who is duly licensed to make such a directive in the ordinary course of his or her professional practice.

**"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.

**"Primary Care Physician"** - a Contracted Physician (a) selected by You to provide or coordinate your Covered Health Services; (b) whose practice predominantly includes internal medicine, family or general practice and pediatrics; and (c) who has entered into a written agreement with SELECTCARE to provide basic Covered Health Services to TEXANPLUS Members. (Under specified circumstances, this Physician may be a Specialty Care Physician).

**"Prior Authorization"** -- Prior Authorization means approval in advance to get certain Network and Non-Network Benefits. Some Network and Non-Network Benefits are covered only if your doctor or other TEXANPLUS Plan provider gets Prior Authorization from SELECTCARE. Please contact your Personal Service Specialist at the number on your identification card if You need information on services that require Prior Authorization.

**"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.

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

**"Semi-private Accommodations"** - a room with two or more beds in a Hospital, Alternate Facility, or Skilled Nursing Facility. The difference in cost between Semi-private Accommodations and private accommodations is covered only when private accommodations are necessary in accordance with generally accepted medical practice or when Semi-private Accommodations are not available.

**"Service Area"** - the geographic area in which SELECTCARE offers TEXANPLUS, as approved by CMS and any appropriate state regulatory agency. Please contact SELECTCARE to determine the precise geographic area in which TEXANPLUS is available. The Service Area may change from time to time. The *Houston Service Area* for TEXANPLUS includes: Brazoria (zip codes: 77581, 77584 and 77588), Fort Bend, Galveston (zip codes: 77546, 77549, 77565, 77573 and 77574), Harris, Montgomery and Counties, Texas and the *Golden Triangle Service Area* for TEXANPLUS includes: Hardin, Jefferson, and Orange Counties, Texas.

**"Sickness"** - physical illness, disease or Pregnancy. The term "Sickness", as used in this EOC, does not include Mental Illness or substance abuse disorders regardless of the cause or origin of the Mental Illness or substance abuse disorders.

**"Specialty Care Physician"** – 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 SELECTCARE, a Specialty Care Physician generally shall not include Physicians in family practice, general practice, internal medicine, or pediatrics.

**"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.

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

**"Substance Abuse Services"** – Covered Health 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 Health 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 this EOC, and further provided that the Premiums required with respect to all such Dependents of the deceased Subscriber are paid.

**"TEXANPLUS Plan"** - is the plan of health care Coverage available to Members under this Evidence of Coverage.

**"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 Health Services"** – Covered Health Services, provided by Contracted or non-Contracted Physicians or other Contracted or non-Contracted providers, **generally in a freestanding Urgent Care Center**, required when: (1) You are temporarily (less than 6 consecutive months) outside the Service Area and are unable to access a Contracted Physician or other Contracted provider to treat an unforeseen Sickness or Injury that is less serious than an Emergency, but that requires prompt treatment to prevent serious deterioration of your health; or (2) You are within the Service Area and in extraordinary cases in which Contracted Physicians or other Contracted providers are unavailable or are inaccessible due to an unusual event.

**SECTION 3**  
**ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE**

**Section 3.1 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 SELECTCARE Requirements**

1. Fully and accurately complete and sign the Application documents provided by SELECTCARE.
2. Be enrolled in Medicare Parts A and B. Only persons with both Medicare Parts A and B are allowed to be enrolled in TEXANPLUS. 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 TEXANPLUS.
3. Reside permanently within the Service Area. (If You reside temporarily outside the Service Area for more than 6 consecutive months, You are deemed a permanent resident elsewhere and are no longer eligible for Coverage and will be disenrolled by SELECTCARE).
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 TEXANPLUS solely due to developing ESRD.

5. Agree, once fully informed, to abide by TEXANPLUS rules and responsibilities (see Member materials) and You must notify SelectCare of any changes in status that affects your ability to meet the eligibility criteria set forth in this Evidence of Coverage.

**B. Group Eligibility Requirements & Enrollment Effective Dates**

1. To be eligible to enroll as a Subscriber in the TEXANPLUS 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, and 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 and You receive benefits from one of the Alternate Health Benefit Plans offered by the City of Houston.

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 prior to the Effective Date, except that a Child over age twenty-five (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 SELECTCARE proof of such incapacity, dependency, and eligibility for Medicare from time to time as SELECTCARE 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 TEXANPLUS 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 TEXANPLUS 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 Evidence of Coverage that pertain to newborn children that may be Medicare eligible.

6. An Eligible Dependent may only become a Dependent under the TEXANPLUS 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 SELECTCARE within thirty-one (31) days of the marriage, shall become covered as of the first day of the month following receipt of a 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 date of the first day of the month following receipt of a 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 SELECTCARE, 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 SELECTCARE a completed 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 a completed 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 3.2 Enrollment.**

Under this EOC, an Eligible Employee or Retiree may apply for enrollment in the TEXANPLUS Plan by submitted a completed Application. In addition, SELECTCARE must receive approval of your enrollment from CMS.

If You meet the above conditions, You cannot be denied Coverage under this EOC on the basis of your health. SELECTCARE 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 TEXANPLUS by completing the Application provided by SELECTCARE or your Employer. When the enrollment has been confirmed by CMS, You will be notified by SELECTCARE of the Effective Date of Coverage.

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

**Section 3.3 Effective Date.** Under this EOC an Eligible Employee or Retiree may apply for enrollment in the TEXANPLUS Plan by submitting a completed Application which is generally effective on the first day of the month following the date your signed, completed Application is received by SELECTCARE.

**Your Effective Date of enrollment in TEXANPLUS is the date indicated on the letter SELECTCARE will send to You to confirm your enrollment in TEXANPLUS.** From that date forward, You must receive all Covered Health Services in accordance with SELECTCARE'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 You or a Dependent has satisfied the eligibility conditions in this Evidence of Coverage on the date that Coverage under this Evidence of Coverage becomes effective, such person shall, as of that date, be covered under this Evidence of Coverage. SELECTCARE, however, shall not be required to cover, arrange for, or otherwise be liable for services rendered prior to the Effective Date or for Confinement or services not covered under this Evidence of Coverage, including those services covered under Extended Benefits coverage of any Alternative Health Benefits Plan.

If for any reason an Application is rejected by CMS, SELECTCARE 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 TEXANPLUS. 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 TEXANPLUS, Medicare Fee-for-Service will not be processing any claims for medical services You receive. SELECTCARE has the financial responsibility for all Medicare-covered health care services You need as long as You follow SELECTCARE's rules on how to receive Covered Health Services.

- If You terminate your Medigap policy and then later disenroll from TEXANPLUS, 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 TEXANPLUS 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 TEXANPLUS 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 TEXANPLUS 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 TEXANPLUS. You may apply for a Medigap policy prior to your disenrollment date with TEXANPLUS in order for that policy to take effect as soon as You return to original Medicare. Please call your Personal Service Specialist for details or more information.

### **What happens if You join or drop out of SELECTCARE during a SNF or Hospital stay?**

If You either join or leave SELECTCARE 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 your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480. They can explain how your services are covered for this stay, and what You owe to SELECTCARE, if any, for the periods of your stay when You were and were not a TEXANPLUS Plan Member.



## SECTION 4 DISENROLLMENT

### What is “disenrollment”?

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

- You might leave SELECTCARE 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 SELECTCARE if You move out of SELECTCARE’s geographic Service Area or if SELECTCARE leaves the Medicare program. SELECTCARE is not allowed to ask You to leave the TEXANPLUS Plan because of your health.

Whether leaving the TEXANPLUS 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 SELECTCARE?

Your options if You leave SELECTCARE include, but are not limited to, the following:

Enrolling in another Medicare Advantage Plan offered by your Employer.	Enrolling in an another Alternative Health Benefits Plan (such as a HMO / PPO).	Discontinue receiving health benefits from your Employer and returning to Original Medicare.
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### How to change from SELECTCARE to another Alternative Health Benefits Plan.

If You want to change from SELECTCARE 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 the plan is accepting new members, apply for membership in the plan. You need to tell SELECTCARE that You are leaving or You will not be disenrolled from SELECTCARE. SELECTCARE also encourages You to tell SELECTCARE 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 SELECTCARE, and must continue to get your medical care as usual through SELECTCARE 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 SELECTCARE or You will have to pay for them yourself**

If You leave SELECTCARE, 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 (SELECTCARE 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 SELECTCARE. If You get services from doctors or other medical providers who are **not** plan providers before your membership in SELECTCARE ends, neither SELECTCARE nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are Urgently Needed Health Services, care for a medical Emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by SELECTCARE. There is another possible exception, if You happen to be hospitalized on the day your membership ends. If this happens to You, call your Personal Service Specialist at the number on the cover of this booklet to find out if your Hospital care will be covered by SELECTCARE. If You have any questions about leaving SELECTCARE, please call your Personal Service Specialist.

All through the year, everyone with Medicare (including members of SELECTCARE) 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 SELECTCARE 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. TEXANPLUS is a Medicare managed care plan offered by SELECTCARE. 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). SELECTCARE 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 SELECTCARE receives your request to leave. For example, if SELECTCARE receives your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if SELECTCARE 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 SELECTCARE?**

If You want to leave SELECTCARE, 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 SELECTCARE 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 SELECTCARE to Original Medicare. (Buying a Medigap policy does not switch You from SELECTCARE to Original Medicare. A Medigap sales person or insurance agent cannot cancel your SELECTCARE membership and put You in Original Medicare.)

- **How to change from SELECTCARE to Original Medicare**

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

1. First, use any of the following ways to tell SELECTCARE that You want to leave SELECTCARE:
  - You can write or fax a letter to SELECTCARE. SELECTCARE's fax number is 713-843-6740. 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. SELECTCARE will then send You a letter that tells You when your membership will end. This is your **disenrollment date** – the day You officially leave SELECTCARE. In most cases, your disenrollment date will be the first day of the month that comes after the month SELECTCARE receives your request to leave. For example, if SELECTCARE 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 SELECTCARE to disenroll You on December 1. Remember, while You are waiting for your membership to end, You are still a Member of SELECTCARE and must continue to get your medical care as usual through SELECTCARE.
3. On your disenrollment date, your membership in SELECTCARE 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 SELECTCARE. (Call Social Security at 1-800-772-1213 if You need a new red, white, and blue Medicare card.)

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

If You want to change from SELECTCARE 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 SELECTCARE will automatically end.** This means that You do not need to tell SELECTCARE that You are leaving. However, SELECTCARE does encourage You to tell SELECTCARE 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 SELECTCARE 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 SELECTCARE until the date your membership ends.

### **What happens to You if SELECTCARE leaves the Medicare program or SELECTCARE leaves the area where You live?**

If SELECTCARE leaves the Medicare program or changes the Service Area so that it no longer includes the area where You live, SELECTCARE will tell You in writing. If this happens, your membership in SELECTCARE 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 SELECTCARE 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 SELECTCARE has told You in writing that SELECTCARE 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 SELECTCARE 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?”

SELECTCARE 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 SELECTCARE or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for SELECTCARE’s contract to end at some other time, too. If the contract is going to end, SELECTCARE 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 SELECTCARE’s contract in the middle of the year.

### **You must leave SELECTCARE 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 your Personal Service Specialist 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 SELECTCARE’s Service Area, or if You are away from SELECTCARE’s Service Area for more than six months in a row, You will need to leave (“disenroll” from) SELECTCARE. In these situations, if You do not leave on your

own, SELECTCARE must end your membership (“disenroll” You). An earlier part of this Section tells about the choices You have if You leave SELECTCARE and explains how to leave.

**Under certain conditions SELECTCARE can end your membership and make You leave the TEXANPLUS Plan**

- **SELECTCARE cannot ask You to leave the TEXANPLUS 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 SELECTCARE 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.

- **SELECTCARE can ask You to leave the TEXANPLUS Plan under certain special conditions**

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

- If You move out of SELECTCARE’s geographic Service Area or live outside the TEXANPLUS Plan Service Area for more than six months at a time (see Section 1 for information about the TEXANPLUS Plan Service Area).
- If You do not stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 3 for information about staying enrolled in Part A and Part B).
- Immediately and without advance written notice if You give SELECTCARE information on your enrollment form that You know is false or deliberately misleading, and it affects whether or not You can enroll in SELECTCARE or You have committed fraud, including fraud in the use of services or facilities, against SELECTCARE. Coverage can be voided for fraud or intentional misrepresentation contained in a written Application. A copy of the written Application must be furnished to You if the terms of the Application or enrollment form are to be applied.
- If You behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects SELECTCARE’s ability to arrange or provide medical care for You or for others who are members of SELECTCARE or to the extent that continued enrollment would seriously impair SELECTCARE’s ability to arrange for services for such Members and/or other enrollees. SELECTCARE cannot make You leave SELECTCARE for this reason unless SELECTCARE gets permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If You let or assist in allowing someone else use your TEXANPLUS Plan membership card to get medical care. Before SELECTCARE asks You to leave SELECTCARE for this reason, SELECTCARE must refer your case to the Inspector General, and this may result in criminal prosecution.

- If there are TEXANPLUS Plan Premiums and if You or your Employer does not pay the TEXANPLUS Plan Premiums, SELECTCARE will tell You that You have a 90-day grace period during which You can pay the TEXANPLUS Plan Premiums before You are required to leave SELECTCARE. Upon the effective date of such termination, prepayments received by SELECTCARE on your behalf for periods after the effective date of termination shall be refunded to You or your Employer.
- **You have the right to make a complaint if SELECTCARE asks You to leave SELECTCARE**

If SELECTCARE asks You to leave SELECTCARE, SELECTCARE will tell You SELECTCARE's reasons in writing and explain how You can file a complaint against SELECTCARE if You want to.

Further, You may request that SELECTCARE conduct a complaint hearing, as provided for and in accordance with SELECTCARE's policies and procedures and CMS regulations, within thirty (30) working days after receiving notice that SELECTCARE has or will terminate your Coverage as described in this Evidence of Coverage. SELECTCARE will continue your Coverage in force until a final decision on the complaint is rendered, provided the Premium is paid throughout the period prior to the issuance of that final decision. SELECTCARE may rescind Coverage, to the date Coverage would have terminated had You not requested a complaint hearing, if the final decision is in favor of SELECTCARE. If Coverage is rescinded, SELECTCARE will refund any Premiums paid by You or your Employer for that period after the termination date, minus the cost of covered benefits provided on your behalf during this period.

Unless otherwise provided for by applicable state or federal law, Coverage will not be terminated on the basis of your health status or health care needs, nor because You have exercised your rights under the Complaint Resolution Procedure to register a complaint against SELECTCARE. The complaint process described in the preceding paragraph applies only to those terminations affected pursuant to this Section 4 of the Evidence of Coverage.

In the event that your Coverage is terminated, SELECTCARE shall have no further liability or responsibility under this Evidence of Coverage for You except for Coverage for covered benefits provided prior to the date of termination of Coverage that were received not as a result of false or misleading information or fraud.

**SECTION 5**  
**PREMIUMS, COPAYMENTS AND COINSURANCE**

**Section 5.1 Premiums.** If You are required to make Premium payments for Coverage through your Employer, those Premium payments must be paid directly to such Employer.

You must continue to pay the appropriate Premiums for Medicare Part A and/or Part B to Medicare while enrolled in TEXANPLUS.

**Section 5.2 Copayments and Coinsurance.** All Copayments and Coinsurance amounts specified in Section 7 of this EOC are payable in addition to any required Premium. Copayments and Coinsurance amounts will be paid directly by You to the provider at the time of service or when billed by the provider.



## **SECTION 6 PROCEDURES FOR OBTAINING COVERED HEALTH SERVICES**

**Section 6.1 Covered Health Services.** The Covered Health Services described in this EOC, including Medicare covered services, are Covered Health Services only if they are ordered, arranged, or provided by or under the direction of your Primary Care Physician You select from the Directory of Physicians and Health Care Providers in the Service Area where You reside, except for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services, and Urgently Needed Health Services and non-referral Covered Health Services as described in Sections 6 and 7 of this EOC. If You receive health services from a Non-Contracted Provider without following SELECTCARE's Coverage Rules, neither SELECTCARE nor CMS will pay the charges. You will be responsible for the cost of those health services. If a provider refuses to provide treatment (including counseling or referral services) on religious or moral grounds, SELECTCARE will assist You in finding another provider. If You temporarily reside outside the Service Area, You are covered only for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services, and Urgently Needed Health Services.

Coverage under TEXANPLUS is subject to the terms, conditions, limitations, and exclusions of this EOC and is also subject to federal legislative changes under Title XVIII, Health Insurance for the Aged and Disabled, of the United States Social Security Act. Coverage is also subject to payment of Premiums, if any, and applicable Copayments and Coinsurance amounts under this EOC. SELECTCARE will be responsible for interpreting Covered Health Services provided under this EOC. SELECTCARE may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to this EOC.

The above conditions are referred to as SELECTCARE's Coverage Rules throughout this EOC. SELECTCARE will offer a uniform benefit package and maintain the appropriate network of providers to meet the required access standards

SELECTCARE, your Primary Care Physician and other Contracted providers will treat You with dignity respect and in a culturally competent manner, and will recognize your right to privacy regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care.

Lock-In Members must obtain all Covered Health Services from or through Contracted Physicians or other Contracted providers in order for those Covered Health Services to be covered under this EOC. This requirement does not apply to Emergency Health Services, post-stabilization care, out-of-area renal dialysis services and Urgently Needed Health Services.

**Referral Health Services.** Referral health services are Covered Health Services only when You receive a referral from your Primary Care Physician. A referral is not required for Emergency Health Services, post-stabilization care, out-of-area renal dialysis services, Urgently Needed Health Services or non-referral Covered Health Services. For Mental Health Services and Substance Abuse Services, the referral must be provided by or through the Mental Health/Substance Abuse Designee.

Primary Care and Specialty Care Physicians are grouped together by both geographical location and practice referral patterns. These Physician groups are individually referred to as a "Local Physician Organization" or "LPO". Once You select a Primary Care Physician in the Service Area where You reside, any additional care You need that cannot be provided by that Primary Care Physician will be provided by a referral specialist, initiated by the Primary Care Physician, and listed in the same LPO as your Primary Care Physician. When You obtain a referral from your Primary Care Physician, You then may make an appointment to see the referred to Physician. After receiving the Covered Health Services provided through the original referral, the referred to Physician or other provider may recommend that You receive additional Covered Health Services. Before receiving these additional Covered Health Services, You should obtain a new referral from your Primary Care Physician.

**Non-Referral Covered Health Services.** Certain health services are Covered Health Services without a referral from your Primary Care Physician when they are provided by a Contracted Physician or other Contracted provider. These Covered Health Services include:

- Eye examinations for refractive corrections (routine vision exams).
- Emergency Health Services, post-stabilization care, out-of-area renal dialysis services or Urgently Needed Health Care services.
- Routine and Preventative women's health services, including clinical breast examination, screening mammograms, pap smears and screening pelvic examinations. Such services must be provided by Contracted Physicians or other Contracted providers who are women's health specialists, gynecologists, certified nurse midwives and other health care providers qualified to provide such services.
- Pneumococcal and Influenza virus vaccine immunizations.
- Mental Health/Substance Abuse Health Services through the Mental Health Designee.

**Section 6.2 Authorization Requirements.** All Covered Health Services not provided by your Primary Care Physician, and not listed in Section 6.1 and Section 6.2, require Prior Authorization from your Primary Care Physician and/or SELECTCARE in the form of a written authorization. Covered Health Services requiring Prior Authorization include but are not limited to:

- a) Inpatient admission/Confinement and extensions of stay beyond the original certified length of stay to a Hospital and Skilled Nursing Facility (elective, non-Emergency and non-Urgently Needed Health Services);
- b) All inpatient and outpatient surgical services;
- c) All Specialty Care Physician services;
- d) Diagnostic and therapeutic services;
- e) All Home Health Agency services;
- f) All prosthetic devices, Durable Medical Equipment, oxygen and medical supplies; and
- g) All services provided by non-Contracted providers.

Whenever You have a question or concern regarding the Covered Health Service authorization requirements under TEXANPLUS please contact your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480.

**Section 6.3 Selection of a Primary Care Physician.** You must select one Primary Care Physician from the TEXANPLUS provider directory who will be responsible for the coordination of all Covered Health Services provided to You, to ensure continuity of care and maintain a central file of your medical records. Your Primary Care Physician must be located in the Service Area where You reside (i.e. either in the Houston Service Area or the Golden Triangle Service Area; see *Section 2*). Primary Care Physicians are grouped together with Specialty Care Physicians by both geographical location and practice referral patterns. These Physician groups are individually referred to as a "Local Physician Organization" or "LPO". Once You select a Primary Care Physician, any additional care You need that cannot be provided by that Primary Care Physician will be provided by a referral initiated by your Primary Care Physician to a specialist listed in the same LPO as your Primary Care Physician. By accepting Coverage, You authorize SELECTCARE and all health service providers to furnish your medical records and information about You to your Primary Care Physician. Enrolling in TEXANPLUS does not guarantee that Covered Health Services will be provided by a particular Primary Care Physician, Contracted Physician or Hospital or other provider on the list of Contracted providers. When a provider no longer has a contract with SELECTCARE or is not currently accepting new TEXANPLUS Members, You must choose among remaining Contracted providers. SELECTCARE will provide You with periodic updates (or anytime at your request) regarding the Contracted status of providers, but it is suggested that You verify the Contracted status of a Physician, Hospital or other provider by calling your Personal Service Specialist. If necessary, your Personal Service Specialist can provide assistance in referring You to Physicians who are Contracted with SELECTCARE.

Within 90 days of the Effective Date of your enrollment, SELECTCARE will contact You to conduct a health status survey. This is particularly important if You have complex or serious Medical Conditions. SELECTCARE has approved procedures to identify, assess, and establish treatment plans for Members with complex or serious Medical Conditions. In addition, SELECTCARE maintains procedures to ensure that Members are informed of health care needs that require follow-up and receive training in self-care and other measures to promote their own health.

You may change your Primary Care Physician at any time by calling your Personal Service Specialist. Your Personal Service Specialist can assist You in selecting a new Primary Care Physician. You should allow at least 31 days for a change in a Primary Care Physician selection to take effect. Most Primary Care Physician changes will be effective on the first day of the month. In the event that You decide to change your Primary Care Physician to a new Primary Care Physician who also was the attending Physician for a recent inpatient stay, the effective date of that Primary Care Physician change will be the first of the month following a ninety (90) day period after the date You were discharged from the Hospital. In order for Covered Health Services to be covered under this EOC, You must continue to obtain Covered Health Services that are provided, ordered or arranged through your current Primary Care Physician until the change takes effect. If You change your Primary Care Physician, and your new Primary Care Physician participates in a different LPO, your specialist referral network may change. Be sure to ask your Personal Service Specialist about this when selecting a new Primary Care Physician.

If your Primary Care Physician's contract with SELECTCARE is terminated (by SELECTCARE or by the Primary Care Physician), SELECTCARE will make every effort to notify You within 30 calendar days prior to the effective date of the termination. For other Contracted Physicians or Contracted providers You will be notified of the termination if You see that Physician or

provider on a regular basis. Contact your Personal Service Specialist for assistance in selecting another Physician or provider.

Should You require hospitalization, your care while hospitalized will be coordinated by your Primary Care Physician or a Contracted admitting Physician. This Physician will follow your Hospital Confinement and will inform You of your condition or progress. If this Physician is not your Primary Care Physician, he or she will also communicate with your Primary Care Physician.

**Section 6.4 Approved Covered Health Services Provided by Non-Contracted Providers.**

In the event that specific Covered Health Services cannot be provided by or through a Contracted provider, You may obtain Covered Health Services from a Non-Contracted provider only with prior approval. Covered Health Services obtained through Non-Contracted providers must be approved in writing, in advance, by SELECTCARE and are subject to the provisions of Section 7 and other limitations and exclusions of this EOC. Emergency Health Services, post-stabilization care, out-of-area renal dialysis services or Urgently Needed Health Services are always covered as Covered Health Services

After receiving the Covered Health Services approved by the original approval, the Non-Contracted provider may recommend that You receive additional health services from him/her. Before receiving any additional services from a Non-Contracted provider, You must receive approval from SELECTCARE. All Covered Health Services identified in this EOC are subject to SELECTCARE's Coverage Rules.

**Section 6.5 Limitations on Selection of Contracted Providers.** If SELECTCARE determines that You are using health services in a harmful or abusive quantity or manner or with harmful frequency, You may be required by SELECTCARE to select a single Contracted pharmacy, a single Contracted Physician and a single Contracted Hospital with which the single Contracted Physician is affiliated for the provision and coordination of all future Covered Health Services.

If You fail to make the required selection of a Contracted Physician and other Contracted providers within 31 days of written notice by SELECTCARE of the need to do so, SELECTCARE will designate the required Contracted Physician or other Contracted providers for You.

Following selection or designation of a Contracted Physician or other Contracted providers, Coverage will be contingent upon Covered Health Services being provided by or through written referral of the designated Contracted Physician or other Contracted providers.

**Section 6.6 Coordinated Care.** In certain circumstances, your Primary Care Physician or other Contracted Physician is required to notify SELECTCARE regarding proposed or scheduled health services. When your Contracted Physician notifies SELECTCARE, SELECTCARE will work with your Contracted Physician to implement a coordinated care process to provide You with information about additional services available through SELECTCARE, such as disease management programs, health education, pre-admission counseling and patient advocacy. SELECTCARE may or may not offer any particular program at a given time and is in SELECTCARE's sole discretion whether to offer these types of programs.

**Section 6.7 Emergency Health Services.** Inpatient or outpatient Medically Necessary Emergency Health Services are always covered as Covered Health Services, inside or outside of the Service Area, within the United States. Emergency Health Services must be provided by or under the direction of licensed providers.

If You require Emergency Health Services You should go to the nearest Hospital or other health care provider to seek and receive care or call 911 for assistance.

Emergency Health Services as defined in Section 2 of this EOC, are covered even when provided by Non-Contracted providers; even if the Medical Condition turns out to be a non-Emergency. Apparent Emergencies are covered and cannot be retrospectively denied by SELECTCARE.

If You receive Emergency Health Services from a Non-Contracted provider, You are encouraged to notify SELECTCARE within 72 hours, or as soon as reasonably possible, after Emergency Health Services are initially provided. At the request of SELECTCARE, You may need to make available full details of the Emergency Health Services received.

“Post-stabilization care” is the Medically Necessary service following an Emergency needed to maintain your stable condition, and in certain circumstances, to improve or cure your condition. Your attending provider determines when your condition is no longer an Emergency and is considered stabilized for discharge or transfer. Post-stabilization care is covered if (a) prior approved by SELECTCARE, or (b) automatically approved because SELECTCARE did not respond to the request by the provider of post-stabilization care services for prior approval within one hour after SELECTCARE was asked to approve post-stabilization care, or (c) automatically approved because SELECTCARE could not be contacted for prior approval despite reasonable efforts.

Such automatic approval of post-stabilization care continues until SELECTCARE has responded to the request and arranged for discharge or transfer. Continuation of care after the condition is no longer an Emergency will require prior approval by your Primary Care Physician or SELECTCARE.

If You are hospitalized in a Non-Contracted Hospital, your attending Physician may consult with your Primary Care Physician or SELECTCARE and recommend your transfer to a Contracted Hospital as soon as it is medically appropriate to do so. If You choose to remain in a Non-Contracted facility after You have been notified of the intent to transfer You to a Contracted facility, health care services provided by Non-Contracted providers or in Non-Contracted facilities will not be covered and You will be responsible for paying those charges.

Medically necessary Emergency Health Services provided to You are subject to the terms, conditions, limitations, and exclusions of this EOC.

**Section 6.8 Urgently Needed Health Services.** Urgently Needed Health Services provided to You when You are temporarily outside the Service Area but within the United States, are Covered Health Services when You follow SELECTCARE’s Coverage Rules. The use of Urgently Needed Health Services is appropriate when those services are required in order to prevent a serious deterioration in your health and cannot be delayed until You return to the Service Area. You do not need a referral from your Primary Care Physician before obtaining Urgently Needed Health Services.

Urgently Needed Health Services provided by a Non-Contracted provider within the Service Area will also be covered as Covered Health Services in extraordinary cases in which Contracted providers are unavailable or are inaccessible due to an unusual event. In non-extraordinary cases, Urgently Needed Health Services in the Service Area are Covered Health Services when ordered, provided or arranged under the direction of your Primary Care Physician or other Contracted Physician.

**Section 6.9 Conditions for Coverage of Mental Health and Substance Abuse Services.**

The Mental Health and Substance Abuse Services specified in Section 7 are covered only when provided, and as approved by the Mental Health/Substance Abuse Designee. Referrals to a Contracted psychiatrist or other Mental Health/Substance Abuse providers, a Contracted Hospital or Contracted Alternate Facility for Mental Health/Substance Abuse Services will in all cases be at the sole discretion of SELECTCARE and/or at the sole discretion of SELECTCARE's Mental Health/Substance Abuse Designee.

**Section 6.10 Second Opinion Policy.** Coverage is also provided for a second opinion at your request. If You request a second opinion, arrangements and prior approval must be made by SELECTCARE for You to obtain Coverage as Covered Health Services. SELECTCARE will designate a Contracted Physician who will perform the evaluation.

**Section 6.11 Hospice Care.** Hospice care is not a Covered Health Service under this EOC; however, Medicare provides a hospice benefit designed to meet the special physical, psychological, spiritual and social needs of Members with a terminal illness and their families. The Medicare benefit includes:

- Physician and nursing services;
- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.
- Physical therapy, occupational therapy, and speech therapy; medical social services and counseling to the Medicare beneficiary and family members;
- Short-term inpatient care, including respite care, that is a short stay for the person with the terminal illness intended to give temporary relief (up to 5 days in a row) to the person who regularly assists with home care;
- *Home care; and*
- Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.

SELECTCARE will assist You in identifying a Medicare-participating hospice if You wish to elect the Medicare-provided hospice benefit. You may remain enrolled in TEXANPLUS even though You have elected Medicare's hospice benefit. You will continue to receive care unrelated to the terminal illness through TEXANPLUS.

If You enroll in a Medicare-certified hospice, Original Medicare (rather than SELECTCARE) pays the hospice for the hospice services You receive. Your hospice doctor can be a TEXANPLUS Plan provider or a non-TEXANPLUS Plan provider. If You choose to enroll in a Medicare-certified hospice, You are still a TEXANPLUS Plan Member and continue to get the rest of your care that is unrelated to your terminal condition through SELECTCARE. If You use non-TEXANPLUS Plan providers for your routine care, Original Medicare (rather than

SELECTCARE) 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, 24 hours a day/7 days a week (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](http://www.medicare.gov). Section 1 tells more about how to contact the Medicare program and about the website.

**Section 6.12 Conditions for Prescription Drug Product Coverage.** Prescription Drug Product Prior Approval is required for certain Prescription Drug Products to be covered. This prior approval is to be obtained from SELECTCARE, or its designee, by the prescribing Physician or the pharmacist. Should You receive Prescription Drug Products requiring prior approval without obtaining prior approval, You will be responsible for all costs associated with that Prescription Drug Product

You will be responsible for 100% of the cost of a Prescription Order or Refill when You fail to show your TEXANPLUS ID at any Contracted pharmacy or if You use the Contracted mail order pharmacy service after a disenrollment.

## SECTION 7 SCHEDULE OF BENEFITS

Covered Health Services described in the benefits chart in Section 1 are subject to the SELECTCARE Coverage Rules. Certain health services require a clinical evaluation in accordance with Medicare coverage guidelines in order to determine whether the services are Covered Health Services. Covered Health services that require a Prior Authorization are identified throughout this Section 7.

**Please note** that You may be responsible for more than one Copayment and/or Coinsurance amount for certain Covered Health Services, such as one for the facility as well as another for the professional services for the same visit.

**Section 7.1 Professional Fees for Covered Health Services in a Physician's Office.** Professional fees for services provided in a Physician's office are Covered Health Services when You follow SELECTCARE's Coverage Rules.

Covered Health Services include, but are not limited to:

- health services ordered and provided by your Primary Care Physician;
- consultations, ordered or referred by your Primary Care Physician to other Contracted Physicians or Contracted providers about your Medical Condition in an office setting;
- routine physical examinations, limited to once per calendar year, in addition to any visits for preventive services listed in Section 7.19;
- Medicare-covered hearing exams (diagnostic hearing exams);
- Pacemaker telephonic evaluation and management services that would otherwise be received at a Contracted Hospital or Contracted Alternate Facility.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$5.00 per visit with your Primary Care Physician; \$25.00 per visit with a Specialty Care Physician or other Contracted office based providers.

**Section 7.2 Professional Fees for Surgical and Medical Services.** Professional fees for surgical and medical services in a Contracted Hospital, Contracted Skilled Nursing Facility, Contracted Long Term Acute Care (LTAC) Facility or Contracted Alternate Facility are Covered Health Services when You follow SELECTCARE's Coverage Rules.

***Requires Prior Authorization (approval in advance) to be covered***

**NO COPAYMENT**

**Section 7.3 Inpatient Hospital and Related Services.** Inpatient Hospital services provided during Confinement in a Contracted Hospital or Inpatient Rehabilitation Facility on a Semi-private Accommodations basis, including room, board, related services and supplies, are Covered Health Services when You follow SELECTCARE's Coverage Rules. A private room is covered when necessary in accordance with generally accepted medical practice or when Semi-private Accommodations are not available. Covered

Health Services provided during a Confinement are subject to SELECTCARE's Coverage Rules.



***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$300.00 per Confinement

**Section 7.4 Inpatient Hospital and Related Services for Transplants.** Inpatient Hospital services provided in a Designated Transplant Facility, including room, board, related services and supplies are Covered Health Services when You follow SELECTCARE's Coverage Rules. The following transplants are Covered Health Services when such services meet SELECTCARE and Medicare coverage guidelines on transplant health services and when You follow SELECTCARE's Coverage Rules:

- Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants are Covered Health Services.
- Heart transplants
- Heart/lung transplants
- Lung (and double lung) transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver transplants
- Liver/small bowel transplants
- Pancreas transplants
- Intestinal transplants

Cornea transplants are also a Covered Health Service when You follow SELECTCARE's Coverage Rules. SELECTCARE does not require that cornea transplants be performed at a Designated Transplant Facility.

Transplants that are Experimental, Investigational or Unproven Services are not Covered Health Services. Transplants are not Covered Health Services unless provided in a Designated Transplant Facility (except cornea transplants) and are subject to the general exclusions in Section 8. Organ or tissue transplants or multiple organ transplants other than those listed above are not Covered Health Services unless specifically covered by Medicare.

Inpatient Hospital transplant services are covered for 90-days of Medically Necessary transplant related hospitalization for each Benefit Period, as defined by Medicare Part A, and up to 60 lifetime reserve days, to a maximum of 150-days (a Benefit Period begins with the first day of a Medicare covered transplant provided in a Designated Transplant Facility, including any continuous Confinement for those transplant health services in an Inpatient Rehabilitation Facility, LTAC Facility and/or a Skilled Nursing Facility, and ends when the Member has been discharged from the aforementioned facilities for a period of 60 consecutive days for transplant health services).

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** (1) \$912.00 per Confinement (100% Coverage for the first 60-days); (2) Additional Copayment: \$228.00 per day for days 61-90 per Benefit

Period; and (3) Additional Copayment: \$456.00 per each lifetime reserve day (maximum 60 lifetime reserve days).

**Section 7.5 Long Term Acute Care (LTAC).** Inpatient Hospital services provided in a Long Term Acute Care (LTAC) facility, including room, board, related services and supplies are Covered Health Services when You follow SELECTCARE's Coverage Rules.

Inpatient Hospital services provided in a Long Term Acute Care (LTAC) facility are covered for 90-days of Medically Necessary LTAC related hospitalization for each Benefit Period to include Medically Necessary inpatient Hospital acute care days, the Benefit Period as defined by Medicare Part A, and up to 60 lifetime reserve days, to a maximum of 150 days. (A Benefit Period begins with the first day of a Medicare covered acute inpatient Hospital, rehab facility, LTAC or SNF stay and ends when the beneficiary has been out of a inpatient Hospital (acute and/or LTAC), rehab facility or SNF for a period of 60 consecutive days for the LTAC admission.)

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** (1) \$300.00 per LTAC admission for the first 60-days of the LTAC admission; this Copayment is waived if the LTAC admission is a transfer admission from an inpatient acute care setting (as described in Section 7.3); (2) Additional Copayment (not waived): \$228.00 per day for days 61-90 per Benefit Period; and (3) Additional Copayment (not waived): \$456.00 per each lifetime reserve day (maximum 60 lifetime reserve days).

**Section 7.6 Inpatient Mental Health and Substance Abuse Services.** Inpatient Mental Health Services and Substance Abuse Services provided during Confinement in a Contracted Hospital or Contracted Alternate Facility on a Semi-private Accommodation basis, including room and board, are Covered Health Services when ordered, provided or arranged under the direction of the Mental Health/Substance Abuse Designee. A private room is covered when necessary in accordance with generally accepted medical practice or when a Semi-private Accommodation is not available.

Inpatient Mental Health Services and supplies are Covered Health Services on a Semi-private Accommodation basis for Mental Health Services when provided in a Medicare-certified psychiatric Hospital approved by SELECTCARE and under the direction of the Mental Health/Substance Abuse Designee not to exceed the 190-day inpatient Medicare lifetime limit during the enrollee's lifetime. This limit does not apply to Mental Health Services provided in a facility other than a psychiatric Hospital (e.g. a psychiatric unit of an acute care Hospital). A private room is covered when necessary in accordance with

generally accepted medical practice or when Semi-private Accommodations are not available.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$300.00 per Confinement

**Section 7.7 Skilled Nursing Facility Services.** Up to 100 days per Benefit Period of Confinement and Skilled Care Services in a Contracted Skilled Nursing Facility or alternate setting approved by SELECTCARE are Covered Health Services when such services meet SELECTCARE and Medicare coverage guidelines and when You follow SELECTCARE's Coverage Rules. Medicare's requirement that a patient spend at least three (3) consecutive days in a Hospital for a related condition before transferring to a Skilled Nursing Facility is not required. The 100-day per Benefit Period limit includes Skilled Nursing Facility days received through SELECTCARE, Medicare or any other Medicare Advantage Organization during that Benefit Period.

Post-hospitalization Skilled Care Services provided through a "home Skilled Nursing Facility" are Covered Health Services when the home Skilled Nursing Facility is: (a) Contracted with SELECTCARE, or (b) if it is not Contracted with SELECTCARE, must agree in writing to accept payment and other terms and conditions that apply to similarly situated Contracted Skilled Nursing Facilities. A "home Skilled Nursing Facility" is a: (i) Skilled Nursing Facility in which You reside at the time of admission to a Hospital, (ii) continuing care retirement community that provides Skilled Care Services in which You reside at the time of admission to a Hospital, or (iii) Skilled Nursing Facility in which your spouse resides at the time You are discharged from a Hospital.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:**

- \$0.00 Copayment for days 1 through 20, inclusive, when transferred from an inpatient acute care level of care (as described in Section 7.3);
- \$300.00 Copayment for days 1 through 20, inclusive, when admitted direct to a Skilled Nursing Facility, without an immediate prior inpatient acute care admission (as described in Section 7.3); and
- \$100.00 per day for days 21 through 100 per Benefit Period.

**Section 7.8 Emergency Health Services.** Covered inpatient or outpatient services furnished by a provider qualified to provide Emergency Health Services, for stabilization or initiation of treatment of Emergency conditions are Covered Health Services when provided by a Contracted or non-Contracted Physician or other Contracted or Non-Contracted provider, **generally at a Hospital's designated emergency room**, in or out of the Service Area but within the United States, when a Medical Condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. Such services, even if the Medical Condition turns out to be a non-Emergency, are Covered Health Services and cannot be retrospectively denied by SELECTCARE.

**COPAYMENT:** \$50.00 per visit. (If Confinement occurs for the same condition within 48 hours, the Copayment for Emergency Health Services will be waived.)

**Section 7.9 Urgently Needed Health Services.** Urgently Needed Health Services are Covered Health Services when provided by Contracted or Non-Contracted Physicians or other Contracted or Non-Contracted providers, **generally in a free-standing Urgent Care Center**, when You are in the Service Area or temporarily outside the Service Area but within the United States and sustain an Injury or unforeseen Sickness, and: (a) those services are required in order to prevent a serious deterioration in your health; and (b) the services cannot be delayed until You return to the Service Area. Urgently Needed Health Services provided by any Physician or other provider within the Service Area are Covered Health Services in extraordinary cases in which Contracted Physicians or other Contracted providers are unavailable or are inaccessible due to an unusual event. In non-extraordinary cases, Urgently Needed Health Services in the Service Area are Covered Health Services when You follow SELECTCARE's Coverage Rules.

**COPAYMENT:** \$50.00 per visit. (If Confinement occurs for the same condition within 24 hours, the Copayment for Urgently Needed Health Services will be waived).

**Section 7.10 Outpatient Mental Health and Substance Abuse Services.** Outpatient Mental Health Services and Substance Abuse Services are Covered Health Services when provided by or under the direction of the Mental Health/Substance Abuse Designee. Partial hospitalization Mental Health Services are Covered Health Services when a Contracted Physician certifies that a Hospital Confinement would be Medically Necessary without it.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$30.00 per day for a partial hospitalization according to Medicare coverage guidelines.

**COPAYMENT:** \$35.00 per individual visit; \$20.00 per group visit.

**Section 7.11 Home Health Agency Services.** Home Health Agency Services are Covered Health Services when determined to be Skilled Care Services by your Primary Care Physician or other Contracted Physicians and when provided by Contracted Home Health Agency providers in your home when You are homebound. Such services must be provided in accordance with SELECTCARE and Medicare coverage guidelines. Home Health Agency Services covered by Medicare consist of: (a) part-time or intermittent skilled nursing care, as defined by Medicare, provided by or under the supervision of a registered professional nurse; (b) physical, speech or occupational therapy considered reasonable, necessary and effective treatment provided by or under the direction of a qualified therapist with the expectation of significant improvement in a reasonably predictable period of time; (c) medical social services under the direction of a Physician; (d) certain medical supplies (other than drugs and biologicals); (e) Durable Medical Equipment; and (f) part-time or intermittent services of Home Health Agency aides.

***Requires Prior Authorization (approval in advance) to be covered***

**NO COPAYMENT**, except there is a Copayment or Coinsurance for Eligible Expenses for Durable Medical Equipment (see Section 7.16), certain medical supplies (see Section 7.16), Outpatient Prescription Drugs (see Section 7.21) and Medicare Part B drugs (see Section 7.20).

**Section 7.12 Rehabilitation Services.** Outpatient rehabilitation services (physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation, and cardiac rehabilitation) are Covered Health Services when provided in accordance with SELECTCARE and Medicare coverage guidelines for rehabilitation services when performed by Contracted Physicians or other Contracted providers, which may include a Comprehensive Outpatient Rehabilitation Facility (CORF), that are likely to result in significant improvement of your condition within a reasonable and predictable period of time as determined in accordance with Medicare coverage guidelines.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$25.00 per visit

**Section 7.13 (A) Outpatient Clinical Laboratory Services and (B) Outpatient Radiologic Services.** (A) Outpatient clinical laboratory services and (B) Outpatient radiologic services are Covered Health Services when You follow SELECTCARE's Coverage Rules.

(A) Outpatient clinical laboratory services

- For laboratory services involving the analysis and collection of biological specimens:

**NO COPAYMENT**

(B) Outpatient radiologic services—***These services require Prior Authorization (approval in advance) to be covered***

- For outpatient radiological services including, but not limited to, clinical/diagnostic, nuclear medicine, echo tests, ultrasound services, non-preventive bone density measurement and standard film x-rays but excluding Radiation Therapy, Intensity Modulated Radiation Therapy, Cardiac Stress tests, MRIs, MRAs, CAT Scans, PET Scans:

**COPAYMENT:**

- (1) \$0.00 per covered benefit outpatient radiological service billed by the provider, when performed in a Contracted Alternate Facility;
  - (2) \$0.00 per x-ray performed in, and billed by, a Contracted Physician's office. However, if the Contracted Physician's office performs other services that generate a Copayment, then the applicable Copayment would apply.
- For Cardiac Stress tests:

**COPAYMENT:** \$25.00 per test.

- For Radiation Therapy:

**COPAYMENT:** \$25.00 per treatment visit.

- For Intensity Modulated Radiation Therapy

**COPAYMENT:** \$100.00 per treatment visit.

- For MRIs, MRAs and CAT Scans:

**COPAYMENT:** \$75.00 per covered benefit service.

- For PET Scans:

**COPAYMENT:** \$150.00 per covered benefit service.

#### **Section 7.14 Outpatient Hospital Services and Outpatient Hospital Observation.**

A.) Outpatient surgery at a Contracted Hospital or a Contracted Alternate Facility are Covered Health Services when You follow SELECTCARE's Coverage Rules.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$125.00 per outpatient service episode of care. (If You are admitted to observation from outpatient surgery, You pay this Copayment; if You are admitted to an inpatient acute level of care (as described in Section 7.3) from outpatient surgery, this Copayment is waived and the inpatient acute Copayment (as described in Section 7.3) applies.

B.) Outpatient Contracted Hospital Observation:

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:**

1. If You are admitted direct to the outpatient Hospital observation, there is \$0.00 Copayment. However, if You are admitted to an inpatient acute level of care (as described in Section 7.3), from the outpatient Hospital observation, within 48 hours of the episode of care, the inpatient acute Copayment (as described in Section 7.3) applies.
2. If You are admitted to the outpatient Hospital observation from the emergency room (up to 48 hours in the emergency room), the emergency room Copayment (as described in Section 7.8) applies.
3. If You are admitted to the inpatient acute level of care (as described in Section 7.3), from the outpatient Hospital observation, as described in (2) above, within 48 hours of the episode of care, the emergency room Copayment (as described in Section 7.8) is waived and the inpatient acute Copayment (as described in Section 7.3) applies.

**Section 7.15 Ambulance Services.** Ambulance transportation in an Emergency is a Covered Health Service when provided in accordance with Medicare coverage guidelines for Emergency ambulance services and is provided by a licensed ambulance service 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.

**COPAYMENT:** \$50.00 per one-way trip

Non-Emergency ambulance transportation is a Covered Health Service when recommended by a Primary Care Physician or other Contracted Physician and provided in accordance with SELECTCARE and Medicare coverage guidelines for non-Emergency ambulance services, and when another form of transportation could endanger your health. The ambulance, equipment and personnel must meet Medicare criteria.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$50.00 per one-way trip.

**Section 7.16 Prosthetic Devices, Orthotic Appliances, and Durable Medical Equipment.** Prosthetic devices, orthotic appliances and Durable Medical Equipment ordered, arranged or provided by or under the direction of your Primary Care Physician or other Contracted provider for use outside a Contracted Hospital or Contracted Skilled Nursing Facility are Covered Health Services when provided in accordance with SELECTCARE and Medicare coverage guidelines. Repair or replacement of devices or equipment is covered only when the present device or equipment no longer fulfills its intended function due to: (a) loss, irreparable damage, or excessive wear, except when loss, damage, or excessive wear is due to your fault; or (b) a significant change in your condition. If more than one type of device or equipment can meet your functional needs, only the most cost-effective device or equipment is a Covered Health Service.

- (a) Prosthetic devices aid body functioning or replace a limb or body part. Orthotic appliances, correct a defect of body form or function. Prosthetic devices and orthotic appliances that result in significant improvement of your condition within a reasonable and predictable period of time as determined in accordance with Medicare coverage guidelines which may include the following: ostomy bags, implant devices, breast prostheses, artificial limbs, artificial eyes and other Medically Necessary prosthetic devices or specially molded orthotic appliances when made necessary as a result of Injury or Sickness. Prosthetic devices also include some Coverage following cataract removal or cataract surgery. See "Eye Care Services" below for more detail.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** 20% of the cost for each covered item.

- (b) Certain Durable Medical Equipment will be provided on a Rental or purchase basis, at SELECTCARE's sole discretion, and includes, but is not limited to, the following:

- braces, including necessary adjustments to shoes to accommodate braces that are permanently attached to the shoe (dental braces are excluded);
- one pair of therapeutic shoes and inserts per calendar year for individuals with severe diabetic foot disease;
- oxygen and the rental of equipment for the administration of oxygen;
- standard wheelchairs;
- standard Hospital-type beds;
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure, except that air-conditioners, humidifiers, dehumidifiers, and other personal comfort items are excluded; and,
- nebulizers.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** 10% of the cost for each covered item.

**Section 7.17 Renal Dialysis Services.** Renal dialysis services when provided in a Medicare-approved renal dialysis facility or in your home when arranged or provided through a Medicare approved renal dialysis facility are Covered Health Services when provided in accordance with SELECTCARE and Medicare coverage guidelines and when You follow SELECTCARE's Coverage Rules. Renal dialysis services will also be covered when furnished in a Medicare-certified renal dialysis facility while You are temporarily outside the Service Area. Renal dialysis services include inpatient dialysis treatments (if You are admitted to a Hospital for special care). Coverage also includes home dialysis equipment and supplies and 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). Coverage begins with the third month after the month in which You begin a course of renal dialysis. If You participate in a self-dialysis training course, there is no benefit-waiting period.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$50.00 per treatment

**Section 7.18 Blood and Blood Products.** Blood, blood components and blood clotting factors that cannot be self-administered are Covered Health Services when prescribed by a Contracted Physician.

***Requires Prior Authorization (approval in advance) to be covered***

**NO COPAYMENT**

**Note:** The Member is responsible for the cost of the first three pints of whole blood or packed red blood cells.



**Section 7.19 Preventive Services.** Preventive services are Covered Health Services when provided in accordance with SELECTCARE and Medicare coverage guidelines and when You follow SELECTCARE's Coverage Rules. These preventive services consist of the following when received from Contracted providers:

**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.

**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 at high risk of colorectal cancer, the following are covered:  
Screening colonoscopy (or screening barium enema as an alternative) every 24 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.

**Immunizations**

- Pneumonia vaccine (You can get this service on your own, without a referral from your PCP).
- Flu shots, once a year in the fall or winter (You can get this service on your own, without a referral from your PCP as long as You get the service from a TEXANPLUS Plan provider).
- If You are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.
- Other vaccines if You are at risk.

***Mammography screening** (You can get this service on your own, without a referral from your PCP)*

- One baseline exam between the ages of 35 and 39.
- One screening every 12 months for women age 40 and older.

**Pap smears, pelvic exams, and clinical breast exam** (You can get these routine women's health services on your own, without a referral from your PCP):

- 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.

**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

**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 your Personal Service Specialists for information on how often SELECTCARE will cover these tests.

**“Welcome to Medicare” physical exam**

For all current members, and for new members whose Medicare Part B coverage begins on or after January 1, 2005: A one-time physical exam within the first 6 months that You have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.

**NO COPAYMENT** for all of these preventive services. You may incur a Copayment for a Physician office visit if other services are provided in addition to these preventive services.

**Section 7.20 Medicare Part B Drugs, Biologicals and Certain Medical Supplies.** The following Medicare Part B drugs, biologicals and certain medical supplies are Covered Health Services and are covered under original Medicare, for everyone with Medicare, when provided in accordance with SELECTCARE guidelines and prescribed by a Contracted Physician.

“Drugs”, as used in this Section 7.20, 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.
- Drugs You take using Durable Medical Equipment (such as nebulizers) that was authorized by SELECTCARE. (See Section 7.16 for an explanation 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. ***This Part B drug requires Prior Authorization (approval in advance) to be covered***
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Erythropoietin by injection if You have end-stage renal disease (permanent kidney failure) and need this drug to treat anemia.
- Intravenous Immune Globulin for treatment of primary immune deficiency diseases in your home.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, Erythropoietin (Epoen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). ***This Part B drug requires Prior Authorization (approval in advance) to be covered***

**COINSURANCE:** 20% of Eligible Expenses. There is no benefit limit, as described below in Section 7.21 “Outpatient Prescription Drugs”, for the drugs covered in this Section 7.20.

The drugs covered under original Medicare are generally drugs that must be administered by a Health Professional. In addition to the drugs listed in this Section 7.20 that are covered by original Medicare and in accordance with SELECTCARE guidelines and prescribed by a Contracted Physician, SELECTCARE offers an outpatient prescription drug benefit. This additional benefit is described below in Section 7.21 under the heading “Outpatient Prescription Drugs”.

**Section 7.21 Outpatient Prescription Drugs.** The Outpatient Prescription Drug benefit includes Coverage for selected Brand-name drugs, all Generic drugs that are approved for use by the U.S. Food and Drug Administration (FDA), as well as insulin. These prescription drugs are Covered Health Services when prescribed by a Contracted Physician and obtained through a Contracted pharmacy or through the Contracted mail order pharmacy service, except in Emergency and Urgently Needed Health Services situations subject to the Copayments and the Annual Benefit Limits listed below. Sections 6.7 (Emergency Health Services) and 6.8 (Urgently Needed Health Services) tell about care for a medical Emergency and Urgently Needed Health Services and Section 9.2 (Payment of Eligible Expenses From Non-Contracted Providers) explains how You can be reimbursed for Emergency and Urgently Needed Services.

<b>Outpatient Prescription Drug Benefit Copayments</b>			
		Retail Pharmacy	Mail Order Pharmacy
Generic Drugs		\$10.00 up to 31 days supply	\$20.00 per 90 days supply
Brand-name Drugs	Formulary	\$30.00 up to 31 days supply	\$60.00 per 90 days supply

Brand-name Formulary Drugs	Non-	\$45.00 up to 31 days supply	\$90.00 per 90 days supply
Non-covered Drugs / Cost after benefit exhausted		100% of the contracted price	100% of the contracted price

- **Brand-name Drugs**, are drugs that are generally produced and sold under the original manufacturer's brand name. The SELECTCARE Formulary is a list of prescription drugs that TEXANPLUS Plan doctors refer to when they need to prescribe drugs. Often they prescribe drugs that are included on the Formulary but sometimes, such as when there is a Generic equivalent drug as explained below or when a certain drug is needed to meet particular clinical criteria, they prescribe drugs that are not on the SELECTCARE Formulary. If You request a Brand-name drug that is not on the SELECTCARE Formulary, that prescription drug will generally be covered under the Brand-name Non-Formulary Outpatient Prescription Drug benefit as explained below.

The SELECTCARE Formulary is developed, reviewed and updated by a committee of doctors and pharmacists on a regular basis throughout the year. This means that drugs can be added to or dropped from the SELECTCARE Formulary at any time, without notice. Brand-name drugs can also be changed from one category of drugs to another within the Formulary. Changes in the SELECTCARE Formulary can affect which drugs are covered for You under the Outpatient Prescription Drug benefit when You fill a prescription. For example, if a Brand-name Non-Formulary drug You are using is added to the SELECTCARE Formulary, You would pay the Copayment shown below for the Brand-name Formulary drug, as long as You have not reached, or exceeded, the annual benefit maximum under the Brand-name Formulary Outpatient Prescription Drug benefit. If a Brand-name Formulary Drug You are using is dropped from the SELECTCARE Formulary, You would pay the Copayment shown below for that Brand-name Non-Formulary drug, as long as You have not reached or exceeded the annual benefit maximum under the Brand-name Non-Formulary Outpatient Prescription Drug benefit..

Also, life-style enhancing drugs (see Section 8 for exclusions) are not covered under the Outpatient Prescription Drug Benefit and You will be responsible for one hundred percent (100%) of the Contracted Rate for such drugs. Furthermore, the cost of any other prescription drugs which are not covered under the Outpatient Prescription Drug Benefit or for prescription drugs after You have exceeded You maximum annual benefit will be your responsibility and will pay one hundred percent (100%) of the Contracted Rate for such drugs. SELECTCARE has negotiated contracts to provide these drugs at a ten to twenty-five percent (10% - 25%) discount off of the regular retail pricing. If You have questions about the SELECTCARE Formulary, or want to get a copy of SELECTCARE's Formulary, call your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480 between the hours of 9:00 am and 5:00 pm CST. In addition, the Formulary is also available on the SELECTCARE web site on the Internet at [www.sctexas.com](http://www.sctexas.com).

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

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 ingredient as the Brand-name drug. The outpatient prescription drug benefit covers all available Generic drugs.

SELECTCARE's Formulary contains the selected Brand-name drugs covered by the Brand-name Formulary Drug benefit. This Formulary is based on how safe and effective certain Brand-name drugs are and how much they cost and does not include all Brand-name drugs. The Brand-name Formulary Outpatient Prescription Drug benefit only covers the Brand-name drugs that are on the Formulary. To get a copy of SELECTCARE's Formulary, call your Personal Service Specialist at 1-866-230-2513 or

TTY at 1-888-685-8480 between the hours of 9:00 am and 5:00 pm CST. In addition, the Formulary is also available on the SELECTCARE web site on the Internet at [www.sctexas.com](http://www.sctexas.com).

Whether a Brand-name drug is on the SELECTCARE Formulary or not affects how much You have to pay when You fill a prescription for a covered drug.

#### **ANNUAL BENEFIT LIMIT:**

**Generic Drugs:** There is no individual annual benefit limit per calendar year for Generic and Medicare Part B Drugs described in Section 7.20. However, if You request a Brand-name Drug when a Generic equivalent is available, You will be responsible for the Generic Copayment plus the difference in ingredient cost between the Brand-name and Generic Prescription Drug Product.

**Brand-name Formulary and Non-Formulary Drugs:** \$4,000.00 combined Formulary and Non-Formulary annual benefit per calendar year (inclusive of retail and mail order). The portion of the Contracted Rate SELECTCARE pays (if any) for each Brand-name Formulary or Brand-name Non-Formulary Outpatient Prescription Drug Product covered by TEXANPLUS and received under any EOC issued to You in any one calendar year is applied toward the Annual Benefit Limit. Copayments or Coinsurance amounts (if applicable) do not count toward the Annual Benefit Limit. Please note that Medicare Part B drugs described in Section 7.20 do not apply toward the Annual Benefit Limit. You will be responsible for one hundred percent (100%) of the cost (including any applicable tax) for the remainder of the calendar year once the Annual Benefit Limit is reached. If You do not reach the Annual Benefit Limit, You are not allowed to carry over the unused portion to the next calendar year.

**Copayment for a Contracted Pharmacy or Contracted Mail Order Pharmacy Service. Please refer to Section 2 for the definition of Generic, Brand-name Formulary, and Brand-name Non-Formulary.**

#### **COPAYMENT: Generic Drugs:**

- Contracted Pharmacy: \$10.00 per Prescription Order or Refill, up to a thirty-one (31) consecutive day supply, for a Generic Prescription Drug Product and insulin (including syringes).
- Contracted Mail Order Pharmacy Service: \$20.00 per Prescription Order or Refill, up to a ninety (90) consecutive day supply, for a Generic Prescription Drug Product and insulin (including syringes).

**Brand-name Formulary Drugs:**

- Contracted Pharmacy: \$30.00 per Prescription Order or Refill, up to a thirty-one (31) consecutive day supply, for a Brand-name Prescription Drug Product on the SELECTCARE Formulary.
- Contracted Mail Order Pharmacy Service: \$60.00 per Prescription Order or Refill, up to a ninety (90) consecutive day supply, for a Brand-name Prescription Drug Product on the SELECTCARE Formulary.

**Brand-name Non-Formulary Drugs:**

- Contracted Pharmacy: \$45.00 per Prescription Order or Refill, up to a thirty-one (31) consecutive day supply, for a Brand-name Prescription Drug Product not on the SELECTCARE Formulary.
- Contracted Mail Order Pharmacy Service: \$90.00 per Prescription Order or Refill, up to a ninety (90) consecutive day supply, for a Brand-name Prescription Drug Product not on the SELECTCARE Formulary.

SELECTCARE generally provides a benefit to cover the cost of the Contracted Rate for a Prescription Drug Product less your Copayment up to the Annual Benefit Limit (if applicable); however, when the Contracted Rate is less than your Copayment, then your Copayment is reduced to the amount of the Contracted Rate. The Contracted Rate is the total amount paid under SELECTCARE's agreement with a Contracted pharmacy or a Contracted mail order pharmacy service for Prescription Drug Products including any applicable tax and applicable dispensing fees. You will be responsible for 100% of the cost of a Prescription Order or Refill when You fail to show your TEXANPLUS ID at any Contracted pharmacy or if You use the Contracted mail order pharmacy service after a disenrollment.

Once You meet or exceed your maximum annual benefit for Brand-name Drugs, will be your responsibility for one hundred percent (100%) of the Contracted Rate for such drugs. SELECTCARE has negotiated contracts to provide You with a ten to twenty-five percent (10% - 25%) discount off of the regular retail pricing.

For the Copayment shown above, You may obtain up to a thirty-one (31) consecutive day supply of a Prescription Drug Product and insulin at a Contracted pharmacy or up to a ninety (90)

consecutive day supply of an Outpatient Prescription Drug using a Contracted mail order pharmacy service, unless adjusted based on (a) the drug manufacturer's packaging or (b) additional supply limits adopted by SELECTCARE that are subject to periodic review and modification. Call your Personal Service Specialist for further information.

### **Important Things To Know About The Outpatient Prescription Drug Benefit**

- The Annual Benefit Limits for Generic and Brand-name drugs are mutually exclusive, and cannot be combined for Coverage purposes. The Annual Benefit Limits for Brand-name Formulary and Brand-name Non-Formulary drugs are a combined \$4,000 limit and not separate limits.
- All Generic drugs and insulin are always Covered Health Services under the Outpatient Prescription Drug benefit.
- From time to time, SELECTCARE may make decisions that affect your Outpatient Prescription Drug Coverage, such as whether a particular drug is covered by SELECTCARE, or whether SELECTCARE approves your doctor's request for an exception to the usual rules about prescription drug Coverage. If You are unhappy about a decision SELECTCARE makes about whether a prescription drug is covered under your Outpatient Prescription Drug benefit, or the amount of payment for a prescription, You have the right to make an appeal (an appeal asks SELECTCARE to reconsider and change SELECTCARE's decision about Coverage or payment). If You want to make any other types of complaints related to your Outpatient Prescription Drug benefit, You may file a "grievance." Section 11 discusses the process for filing of grievances and appeals. You can also call your Personal Service Specialist to get additional information or help with a grievance or appeal.
  
- The Outpatient Prescription Drug Brand-name Formulary benefit covers certain drugs which have been identified as meeting certain clinical guidelines and which are included under the Formulary established by SELECTCARE. SELECTCARE would consider exceptions and cover certain Brand-name Non-Formulary drugs under the Brand-name Formulary Outpatient Prescription Drug benefit only under special circumstances. For example, a provider may request and identify that there may be specific clinical reasons why a Brand-name Non-Formulary drug is needed in place of a Brand-name Formulary drug. In this situation, your doctor would request approval in advance, called a "prior approval," from SELECTCARE in order for the Brand-name Non-Formulary drug to be covered under the Brand-name Formulary Outpatient Prescription Drug benefit. If SELECTCARE denies a request for an exception, You have a right to appeal that request (see Section 11 for more information on appeals).

Exclusions from this Section 7.21 include but are not limited to:

- (a) Any Prescription Drug Product that is considered to be life-style enhancing or cosmetic, including, but not limited to, drugs prescribed to treat sexual dysfunction (such as Levitra, Viagra, or Cialis), enhance athletic or mental performance, hair loss (such as Propecia) or anti-aging drugs.
- (b) Medicare Part B drugs, biologicals and certain medical supplies covered under Section 7.20 do not count toward your maximum annual benefit, but are a covered benefit.

- (c) Drugs that are prescribed, dispensed or intended for use while You are Confined in a Hospital, Skilled Nursing Facility, LTAC Facility, Alternate Care Facility, or Inpatient Rehabilitation Facility.
- (d) Prescription Drug Products if the amount dispensed exceeds the applicable supply limits.
- (e) Appetite suppressants and weight loss products.
- (f) Experimental, Investigational or Unproven drugs.
- (g) Prescription Drug Products for smoking cessation.
- (h) Drugs available over-the-counter (OTC) that do not require a Prescription Order or Refill by federal or state law. Prescription Drug Products that are therapeutically equivalent to an OTC drug. Prescription Drug Products that are composed of components that are available in the over-the-counter form or equivalent.
- (i) Drugs that are not FDA approved. Drugs that are FDA approved when prescribed for a non-FDA approved indication (off-label use).
- (j) Injectable drugs (including self-administered injectable drugs) other than insulin, bee sting kits and glucagon kits.
- (k) Compounded Drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
- (l) Unit dose packaging of Prescription Drug Products.
- (m) Durable Medical Equipment covered in Section 7.16.
- (n) Prescribed and non-prescribed outpatient supplies other than the diabetic supplies specifically stated as covered.
- (o) General and injectable vitamins, except the following that require a Prescription Order or Refill to be dispensed: prenatal vitamins, vitamins with fluoride, and single-entity vitamins.
- (p) Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- (r) Prescription Drug Products when prescribed to prevent conception, including diaphragms and Depo Provera.
- (s) Prescription Drug Products when prescribed to treat infertility.



While SELECTCARE has excluded these drugs and products from the Outpatient Prescription Drug Benefit, SELECTCARE has negotiated contracts to provide these drugs and products at a ten to twenty-five percent (10% - 25%) discount off of the regular retail pricing. You will be responsible for one hundred percent (100%) of the Contracted Rate for such drugs and products.

**Section 7.22 Medicare Required Dental Services.** Dental services, for surgery of the jaw is 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 medical Physician, are Covered Health Services when provided in accordance with Medicare coverage guidelines and You follow SELECTCARE's Coverage Rules.

***Requires Prior Authorization (approval in advance) to be covered***

**NO COPAYMENT**

**Section 7.23 Eye Care Services.** Eye care services are Covered Health Services when You follow SELECTCARE's Coverage Rules. These services consist of:

- (a) routine vision examinations including refractions to determine the need for vision correction (limited to once per calendar year).

**COPAYMENT:** \$25.00 per visit

- (b) annual glaucoma screening for individuals at high risk for glaucoma, individuals with a family history of glaucoma, or individuals with diabetes.

**COPAYMENT:** \$25.00 per visit

- (c) ophthalmologic services related to a complaint or symptoms of an eye Sickness or Injury; routine ophthalmologic services are not Covered Health Services.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$25.00 per visit

- (d) corrective lenses required after cataract surgery. If corrective lenses are required following cataract surgery, TEXANPLUS covers 100% of the cost of eyeglass lenses and/or contact lenses and up to \$50.00 toward the cost of eyeglass frames. This is limited to the first pair of eyeglasses or contact lenses following each cataract surgery in which You receive an intraocular lens. Tinting and scratch-resistant coating are not Covered Health Services.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:**

(1) NO COPAYMENT for eyeglass lenses or contact lenses, limited to the first pair of eyeglasses or contact lenses following each cataract surgery in which You receive an intraocular lens.

(2) COPAYMENT: \$50.00 benefit for the cost of eyeglass frames following each cataract surgery.

**Section 7.24 Reconstructive Surgery.** Reconstructive Surgery is a Covered Health Service when You follow SELECTCARE's Coverage Rules. For the purposes of this EOC, breast reconstruction following a mastectomy or bilateral mastectomy, reconstruction of the non-affected breast to achieve symmetry, breast prosthesis and treatment of complications are also Covered Health Services when provided in accordance with SELECTCARE guidelines and when You follow SELECTCARE's Coverage Rules.

***Requires Prior Authorization (approval in advance) to be covered***

**NO COPAYMENT:** (for exceptions on Copayments, refer to Sections 7.1, 7.2, 7.3 and 7.14)

**Section 7.25 Spinal Manipulation Services.** Manual manipulation of the spine to correct a subluxation (minor dislocation) is a Covered Health Service when provided in accordance with Medicare coverage guidelines and You follow SELECTCARE's Coverage Rules.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$25.00 per visit.

**Section 7.26 Podiatry Services.** Services to treat Injuries and diseases of the foot in order to maintain the feet in a healthy condition are Covered Health Services when provided in accordance with Medicare coverage guidelines and when You follow SELECTCARE's Coverage Rules. Treatments for flat foot or foot subluxation or other routine foot care are not Covered Health Services.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$25.00 per visit.

**Section 7.27 Outpatient Diabetes Self-Monitoring Training and Supplies.**

Outpatient Diabetes Self-Monitoring Training is a self-management program that educates the Member in the self-management of diabetes. It includes education about self-monitoring of blood glucose, diet and exercise, an insulin treatment plan for patients who are insulin dependent and self-motivation skills.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$0.00 per visit.

Outpatient Diabetes Supplies provides Coverage of blood glucose monitors, test strips for Members with diabetes, whether insulin dependent or not and lancets, glucose control solutions for checking the accuracy of test strips and monitors and for persons at risk of diabetes, fasting plasma glucose tests. Contact your Personal Service Specialist for information on how often SELECTCARE will cover these tests.

**(see Section 7.20 Medicare Part B Drugs, Biologicals and Certain Medical Supplies.)**

**COINSURANCE:** 10% of Eligible Expenses.

**Section 7.28 Medical Nutrition Therapy Services.** Medical Nutrition Therapy Services are for individuals with diabetes or renal disease.

***Requires Prior Authorization (approval in advance) to be covered***

**COPAYMENT:** \$25.00 per visit.

**Section 7.29 Annual Out-of-Pocket Maximum.** There is a limit to how much You will have to pay for specified covered health care services (listed below) each year. During the year, if the amount that You spend on your Copayments and Coinsurance as a Member of SELECTCARE for these specified Covered Health Services exceeds \$1,500.00, we will begin to pay for all of the specified Covered Health Services listed below.

Specified Covered Health Services include the following: 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 Services, Urgently Needed Health Services, Outpatient Rehabilitation Services, Durable Medical Equipment, Prosthetic Devices, Cardiac Rehabilitation Services, Renal Dialysis, Diabetic Self-Monitoring Training and Supplies, Comprehensive Outpatient Rehabilitation Facility (CORF) Services, and Partial Hospitalizations.

Those costs which are specifically excluded from the Annual Out-of-Pocket Maximum, include, but are not limited to, Outpatient Prescription Drugs, Copayments for your Primary Care Physician and/or Specialty Care Physician, and any and all services or benefits not specifically included and identified above.

**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, SELECTCARE want to help. Whenever You have a question or concern regarding the Covered Health Services under TEXANPLUS, a provider's Contracted status or any required procedure, please contact your Personal Service Specialist at 1-866-230-2513 or

TTY at 1-888-685-8480. 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 11 for information about making a complaint.

### **Can your benefits change during the year?**

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

- If SELECTCARE decides 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 SELECTCARE decides to provide more of some benefit that You already have, this would be an increase in your benefits.
- If SELECTCARE decides to reduce the amount of a Copayment, Coinsurance, or TEXANPLUS Plan Premium, this would also be an increase in your benefits because You would be getting the same benefits for less money.

If SELECTCARE decides to increase any of your benefits during the calendar year, SELECTCARE will let You know in writing.

**The Medicare program does not allow SELECTCARE to decrease your benefits during the calendar year.** SELECTCARE is allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any decreases SELECTCARE makes in your benefits. SELECTCARE will tell You in advance (in October 2005) 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 SELECTCARE covers what Original Medicare covers, SELECTCARE 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. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, You will have to pay Original Medicare out-of-pocket amounts for those services. SELECTCARE will let You know in advance if You will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

## Section 8 General Exclusions

**Section 8.1 Exclusions.** The following are not covered:

- (a) Health services and supplies that do not meet the criteria for a Covered Health Service (see Section 2) and services that are not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. As noted in Section 7, SELECTCARE provides all covered services according to Medicare guidelines.
- (b) Except as provided in Section 7 and/or in accordance with Medicare guidelines, services provided by a Doctor of Dental Surgery, "D.D.S.", or by a Physician licensed to perform dental services (including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone and services for the treatment of temporomandibular joint syndrome) whether the services are considered to be medical or dental in nature. Dental x-rays, supplies and appliances (including occlusal splints) and all associated expenses arising out of such dental services including hospitalizations, except as might otherwise be required for treatment of dentition problems related to an appropriate diagnosis, in SELECTCARE's judgment, of acute traumatic Injury or cancer. Excluded dental care also includes, but is not limited to, routine cleanings, filling, fluoride supplements or treatments, teeth whitening products or services, braces or other orthodontia, porcelain veneers, or dentures.
- (c) Custodial Care, domiciliary care, respite care or rest cures, or private duty nursing, including homemaker services and nursing care on a full-time basis in your home.
- (d) Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- (e) Services and associated expenses for Cosmetic Procedures or procedures merely for the convenience of the Member including, but not limited to pharmacological regimens, nutritional procedures or treatments, full body CT scans (and similar procedures) and plastic surgery.
- (f) Services and associated expenses for procedures, including any expenses associated with the evaluation for such procedures, intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and services of a similar nature, unless an integral part of a course of treatment for hypothyroidism, Cushing's Disease, hypothalamic lesions, diabetes or hypertension or specifically required by Medicare guidelines to be covered. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and services and supplies of a similar nature.
- (g) Services and associated expenses for Experimental, Investigational or Unproven Procedures, treatments, devices and pharmacological regimens. The fact that an Experimental, Investigational or Unproven Procedure, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

- (h) Services and associated expenses for megavitamin therapy; psychosurgery; radial keratotomy, LASIK surgery, visions therapy and other low vision aides and services, and other refractive eye surgery; nutritional-based therapy for alcoholism or other chemical dependency; dermabrasion, salabrasion, chemosurgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne; acupuncture; accupressure; hypnotism; rolfing; massage therapy; aroma therapy; and other forms of alternative treatment (including naturopaths' services); services and supplies for smoking cessation programs and treatment of nicotine addiction.
- (i) Services and associated expenses for removal of an organ from a Member for purposes of transplantation into another person. Coverage is not excluded for health services and acquisition costs and associated expenses for removal of an organ from another person for purposes of transplantation into a Member, if the transplant is provided in accordance with Section 7. Services and associated expenses for transplants involving mechanical or animal organs unless covered by Medicare.
- (j) Services and associated expenses for organ or tissue transplants are excluded, except those specifically stated in Section 7 and in accordance with SELECTCARE's and Medicare guidelines for transplantation health services.
- (k) Services and associated expenses for infertility services; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor ovum and semen and related costs including collection and preparation; and amniocentesis.
- (l) Services and associated expenses for sex transformation operations and the voluntary sterilization or reversal of voluntary sterilization.
- (m) Prosthetic and orthotic devices, Durable Medical Equipment and appliances, and personal comfort items, including, without limitation, air-conditioners, whirlpool tubs, and saunas even though prescribed by a Physician, except as provided under Section 7 of this EOC.
- (n) Charges incurred in connection with the provision and fitting of hearing aids, eyeglasses and contact lenses, except as provided in Section 7.
- (o) Travel or transportation expenses, except ambulance and transportation service as specifically described in Section 7, even though prescribed by a Physician.
- (p) Mental Health and/or Substance Abuse Services required by order of a court when such services are inconsistent with the assessment and treatment plan of the Mental Health/Substance Abuse Designee.
- (q) Mental Health Services determined not to be Medically Necessary for the treatment of a specific Mental Illness based on Medicare guidelines.

- (r) Prescription medications for outpatient treatment; prescribed or non-prescribed non-durable medical supplies including but not limited to elastic stockings, ace bandages, gauze, and like products; over-the-counter drugs and treatments; growth hormone therapy for any condition which has not been appropriately diagnosed as an actual growth hormone deficiency. This exclusion (r) does not apply to those supplies that are covered by Medicare.
- (s) Physical, psychiatric or psychological examinations or testing or vaccinations, immunizations or treatments not otherwise covered under this EOC or in accordance with Medicare guidelines, when such services are for purposes of obtaining, maintaining or otherwise relating to career education, sports, travel, employment, insurance, marriage, adoption or relating to judicial or administrative proceedings or orders or which are conducted for purposes of medical research or to obtain or maintain a license of any type.
- (t) Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- (u) Services provided by a provider with the same legal residence as You or who is a member of your family, including spouse, brother, sister, parent or Child.
- (v) Services otherwise covered under this EOC, but provided after the date individual Coverage under this EOC terminates, including services for Medical Conditions arising prior to the date Coverage terminates (except as outlined in Section 4).
- (w) Services for which You have no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under this EOC.
- (x) Services for which Coverage is available, if a proper claim were made, by workers' compensation, occupational disease law or similar legislation.
- (y) Chiropractic services, treatment or care including but not limited to services and supplies provided by or under the direction of a chiropractor; chiropractic manipulations and adjustments; adjunctive therapy; examination; x-rays; tests; diagnostic and therapeutic services; supplies and appliances, except for spinal manipulation done for purposes of correcting subluxation and in accordance with Section 7.
- (z) High dose chemotherapy and related services involving removal from the body and subsequent return of your own blood cells of any type, except as a treatment for an appropriate diagnosis in accordance with Medicare guidelines.
- (aa) Services and associated expenses for implants (including breast implants) are excluded, except as specifically stated in Section 7 and in accordance with Medicare guidelines; repair or replacement for any otherwise covered implant.
- (bb) Services that are provided by a provider who has opted out of Medicare by choosing to enter a written private contract with a Medicare beneficiary to provide services that would otherwise be covered by Medicare except for Emergency Health Services, post-

stabilization care, out-of-area renal dialysis services and Urgently Needed Health Services.

- (cc) Services relating to sexual function or dysfunction, including, but not limited to, breast augmentation, breast reduction, penile implants, or drugs prescribed to treat sexual dysfunction (including erectile dysfunction, impotence, anorgasmia or hyporgasmia), except for services related to an appropriate diagnosis, in SELECTCARE's sole judgment, of acute traumatic Injury or cancer.
- (dd) Services furnished while in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute unless both of the following conditions are met:
  - 1. The state or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, **and**
  - 2. The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare, SELECTCARE, or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.
- (ee) Services that are provided which are not Medically Necessary or which are not covered by Medicare, except for those services identified herein this EOC.
- (ff) 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 SELECTCARE, SELECTCARE will reimburse veterans for the difference. Members are still responsible for the SELECTCARE cost sharing amount.
- (gg) Meals delivered to your home.
- (hh) Cosmetics, self-administered vitamins, diet pills, health and beauty aids, and homeopathic medications.



## SECTION 9 PROCEDURES FOR REIMBURSEMENT

**Section 9.1 Payment of Eligible Expenses From Contracted Providers.** Contracted providers are responsible for submitting a request for payment of Eligible Expenses directly to SELECTCARE. In the event You are billed by a Contracted provider for Eligible Expenses beyond your Copayment or Coinsurance amount, You should contact your Personal Service Specialist at 1-866-230-2513 or TTY at 1-888-685-8480.

**Section 9.2 Payment of Eligible Expenses from Non-Contracted Providers.** SELECTCARE 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 Health Services approved by SELECTCARE in accordance with the terms of this EOC. Non-Contracted providers should submit bills to SELECTCARE for payment. However, if You paid for such Covered Health Services from a Non-Contracted provider You should contact your Personal Service Specialist. You are required to pay any Copayment or Coinsurance amount required under the EOC for those Covered Health Services.

If You paid for Covered Health 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 Health Services to SELECTCARE as soon as possible but no later than the time limits specified in the table below:

**For services received between:**  
**Jan. 1 and Sept. 30**

**Oct. 1 and Dec. 31**

**Submit your request by:**  
**Dec. 31 of the year following the year in which services were received.**  
**Dec. 31 of the second year following the year in which services were received.**

- The request for reimbursement must be presented on a form provided by or approved by SELECTCARE by calling your Personal Service Specialist. You must attach an itemized statement (an explanation of the situation, the bill, and a receipt or canceled check) for the Covered Health Services.
- The request for reimbursement of Eligible Expenses can be submitted to SELECTCARE at the following address:

**TEXANPLUS Claims**  
**SelectCare of Texas, LLC**  
**P.O. Box 741107**  
**Houston, Texas 77274-1107**

- Within 15 days after SELECTCARE receives your written request for reimbursement, SELECTCARE will:

- (a) acknowledge receipt of the request for reimbursement;
  - (b) begin any investigation of the request for reimbursement;
  - (c) specify the information You must provide to file the request for reimbursement. (SELECTCARE can request additional information during the investigation, if necessary).
- Within 15 business days after SELECTCARE receives all the information required to approve the request for reimbursement, SELECTCARE 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 SELECTCARE needs more time to make the decision and the reasons needed for the additional time. However, SELECTCARE will notify You of the final decision within 45 days from the date of receipt.

SELECTCARE will reimburse You for accepted Covered Health 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 Health Services instead of being paid to You.

SELECTCARE will advise You of SELECTCARE'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 SELECTCARE within 30 calendar days, but no more than 60 calendar days, after receipt of the request for reimbursement.

**Section 9.3 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 SELECTCARE within 3 years of the expiration date described above, You forfeit your rights to bring any action against SELECTCARE. Exceptions to this limitation include the time limits set forth in Section 11 that apply to the Medicare Appeals Process.

## **SECTION 10 COORDINATION OF BENEFITS AND SUBROGATION**

**Section 10.1 Coordination of Benefits (COB).** SELECTCARE is always the primary payor, except if You have coverage through:

- workers' compensation insurance
- black lung benefits
- automobile medical insurance
- no fault insurance
- any liability insurance
- group health plans (20 or more employees) if You are age 65 or over and are entitled to Medicare and have coverage on the basis of your current employment or your spouse's (of any age) current employment status under another health plan.
- group health plans (of any size) during the first 30 months following Medicare eligibility when You are entitled to Medicare due to end stage renal disease (ESRD)
- large group health plans (of 100 or more employees) if You are entitled to Medicare due to a disability (other than ESRD) and You have coverage on the basis of your own or a family member's current employment status

You agree to promptly respond if You receive a request from SELECTCARE or its designee for information about other insurance You may have. If You have other insurance, SELECTCARE may require that You assist in obtaining payment and/or payment information from the other insurer.

**Please keep SELECTCARE 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 SELECTCARE, 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 (COB) 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 SELECTCARE know if You have additional insurance**

You must tell SELECTCARE if You have any other health insurance coverage besides TEXANPLUS, and let SELECTCARE 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 SELECTCARE coordinates your benefits as a Member of TEXANPLUS with your benefits from other insurance depends on your situation. With coordination of benefits, You will often get your care as usual through SELECTCARE, 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 SELECTCARE, You may get your care outside of SELECTCARE.

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 SELECTCARE and You will not have to be involved. However, if payment owed to SELECTCARE is sent directly to You, You are required under Medicare law to give this payment to SELECTCARE. 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 your Personal Services Specialist 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, **24 hours a day/7 days a week** (1-800-633-4227; TTY 1-877-486-2048), or by visiting the [www.medicare.gov](http://www.medicare.gov) website.

**Section 10.2 Subrogation and Reimbursement.** A provision will apply that SELECTCARE 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 TEXANPLUS Plan benefits, but only to the extent of such benefits. Upon receiving such benefits from SELECTCARE, the enrollee is considered to have assigned such rights of recovery to SELECTCARE and to have agreed to give SELECTCARE any reasonable help required to secure the recovery. SELECTCARE will be entitled to recover reasonable attorney fees and court costs in connection with such recovery.

**SECTION 11**  
**APPEALS AND GRIEVANCES:**  
**WHAT TO DO IF YOU HAVE CONCERNS OR COMPLAINTS**  
(how to handle problems related to your Coverage, including payment for your care; problems about Hospital discharge; and other types of problems)

SELECTCARE encourages You to let SELECTCARE know right away if You have questions, concerns, or problems with any part of your Coverage. Please call SELECTCARE whenever You have a question about this or any other part of the health plan.

This Section explains what You can do to deal with any problems You may have. It 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 Member of SELECTCARE. The Medicare program has helped set the rules about what You need to do to make a complaint, and what SELECTCARE is required to do when SELECTCARE receives a complaint. You cannot be dropped from SELECTCARE or be penalized in any way if You make a complaint.

In this Section, **SELECTCARE uses the word “complaint” in a general way to mean an action You can take to deal with a problem.** There are different rules for making complaints depending on the type of problem You are having. This Section has separate parts that give the rules for each of the following situations:

1. **Complaints related to your Coverage, including payment for your care.** This includes whether a particular treatment or other care You want is covered by SELECTCARE. It also includes whether SELECTCARE will pay for care You have received that You think is covered by SELECTCARE.
2. **Complaints about being discharged from the Hospital too soon**
3. **Complaints if You think your Coverage for Skilled Nursing Facility, Home Health Agency or comprehensive outpatient rehabilitation facility services is ending too soon**
4. **Making complaints (called “grievances”) about any other type of problem You have with SELECTCARE or one of the TEXANPLUS Plan providers**

As You will see later in this Section, a complaint that asks for a decision about Coverage or payment for care to be reconsidered is called an “**appeal**” or a “request for reconsideration.” A complaint about quality of care is called a “**grievance**” (complaints about quality of care fall under the category of “complaints about all other types of problems”).

### **Complaints Related to Your Coverage, Including Payment for Your Care**

This part of Section 11 explains what You can do if You have problems getting the medical care You believe that SELECTCARE should provide. SELECTCARE uses the word “provide”

in a general way to include such things as authorizing care, paying for it, arranging for someone to provide it, or continuing to provide a medical treatment You have been getting.

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 Member of SELECTCARE, including payment for care received while a Member of SELECTCARE. 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 SELECTCARE;
- If SELECTCARE will not authorize the medical treatment your Physician or other medical provider wants to give You, and You believe that this treatment is covered by SELECTCARE;
- 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; and
- If You have received care that You believe is covered by SELECTCARE, but SELECTCARE has refused to pay for this care.

### **How Does the Medicare 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 deny (turn down) your request completely. 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.” If You continue with your complaint by going on to Step 2, it is called making an “appeal” or a “request for reconsideration” of SELECTCARE’s 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 through Step 6, also involves appealing a decision.
- **Who makes the decision at each step?** In Step 1, You make your request for Coverage or payment for care directly to SELECTCARE. SELECTCARE reviews this request, and then makes an initial decision. If SELECTCARE’s initial decision turns down your request, You can go on to Step 2, where You “appeal” this initial decision (asking SELECTCARE to reconsider). After Step 2, your appeal goes outside of SELECTCARE, where people who are not connected to SELECTCARE 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.

- **A note about terminology.** In this Section 11 SELECTCARE uses simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, SELECTCARE generally will say “initial decision” instead of “initial Organization Determination”, and will use the word “fast” rather than “expedited” when referring to decisions that are made more quickly than the standard time frame. Instead of saying “adverse decision”, SELECTCARE will use “deny your request”, or “turn down your appeal”. SELECTCARE uses “independent review organization” rather than “independent review entity”.

## **STEP 1: SELECTCARE 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 SELECTCARE is the starting point for dealing with requests You may have about your Coverage or payment for your care. With this decision, SELECTCARE informs You whether SELECTCARE 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 SELECTCARE’s 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 (an “appeal”) if SELECTCARE fails to make a timely “initial decision” on your request.

- If You ask SELECTCARE 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 SELECTCARE to get help in making this request.
- If You ask for a specific type of medical treatment from your Physician or other medical provider, this is a request for an “initial decision” about whether the treatment You want is covered by SELECTCARE. Depending on the situation, your Physician or other medical provider may make this decision on behalf of SELECTCARE, or may ask SELECTCARE to authorize the treatment. You may want to ask SELECTCARE for an initial decision without involving your Physician. You can call SELECTCARE to get help in making this request.

**When SELECTCARE makes an “initial decision,” SELECTCARE provides an interpretation of how the benefits and services that are covered for Members of SELECTCARE apply to your specific situation.** This EOC and any Amendments You may receive describe the benefits and services covered by SELECTCARE, including any limitations that may apply to these services. This EOC also lists exclusions (services that are “not covered” by SELECTCARE).

### **Who may ask for an “initial decision” about your medical care or payment?**

You can ask SELECTCARE 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, Physician, 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 your authorized representative must sign and date a statement that gives this person legal permission to act for You. This statement must be sent to SELECTCARE. You can call SELECTCARE 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.

### **“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 SELECTCARE 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 Physician 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 this address:

**SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

#### **Asking for a fast decision**

You, any Physician, or your authorized representative can ask SELECTCARE to give a “fast” decision (rather than a “standard” decision) about medical care by calling SELECTCARE at 1-866-230-2513 or TTY at 1-888-685-8480. Or, You can deliver a written request to:

**SelectCare of Texas, LLC**



**4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

Requests may also be faxed to SELECTCARE at (713) 843-6740, to the attention of the Appeals Department. Be sure to ask for a “fast” or “72-hour” review.

- If any Physician asks for a fast decision for You, or supports You in asking for one, and the Physician indicates that waiting for a standard decision could seriously harm your health or your ability to function, SELECTCARE will automatically give You a fast decision.
- If You ask for a fast initial decision without support from a Physician, SELECTCARE will decide if your health requires a fast decision. If SELECTCARE decides that your Medical Condition does not meet the requirements for a fast initial decision, SELECTCARE will send You a letter informing You that if You get a Physician’s support for a “fast” review, SELECTCARE will automatically give You a fast decision. The letter will also tell You how to file a “grievance” if You disagree with SELECTCARE’s decision to deny your request for a fast review. If SELECTCARE denies your request for a fast initial decision, SELECTCARE 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 SELECTCARE must decide, depends on the type of decision:

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

After SELECTCARE receives your request, SELECTCARE has 30 calendar days to make a decision. However, if SELECTCARE needs more information in order to make a decision, SELECTCARE can take up to 30 more days. You will be told in writing when SELECTCARE makes a decision. If SELECTCARE does not approve your request for payment, SELECTCARE must tell You why, and tell You how You can appeal this decision. If You have not received an answer from SELECTCARE 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:**

After SELECTCARE receives your request, SELECTCARE has up to 14 calendar days to make a decision, but SELECTCARE will make it sooner if your health condition requires. However, SELECTCARE is allowed to take up to an additional 14 calendar days to make a decision (a) if You request this extension of time, or (b) if SELECTCARE needs more time to gather information that may benefit You. For example, SELECTCARE may need more time to get information that would help SELECTCARE approve your request for medical care (such as medical records). When SELECTCARE takes additional days, SELECTCARE will notify You in writing of this extension. If You feel that SELECTCARE should not take additional days, You can make a specific type of complaint called a “grievance”, as described in this Section 11.

SELECTCARE will tell You in writing of SELECTCARE's initial decision concerning the medical care You have requested. You will receive this notification when SELECTCARE makes the decision, under the time frame explained above. If SELECTCARE does not approve your request, SELECTCARE must explain why, and tell You of your right to appeal the decision. Step 2 tells how to file this appeal.

If You have not received an answer from SELECTCARE within 14 calendar days of your request for the initial decision, this failure to receive an answer is the same as being told that your request was not approved, and You have the right to appeal. If SELECTCARE tells You that SELECTCARE has extended the number of days needed for a decision and You have not received an answer from SELECTCARE by the end of the extension period, this 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.

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

If You receive a "fast" review, SELECTCARE will give You the result of the decision about your medical care within 72 hours after You or your Physician asks for a "fast" review -- sooner if your health requires. However, SELECTCARE is allowed to take up to 14 more calendar days to make this decision if SELECTCARE finds that some information is missing which may benefit You, or if You need more time to prepare for this review. If You feel that SELECTCARE should not take any additional days, You can make a specific type of complaint called a "grievance", as described in this Section 11.

SELECTCARE will tell You the decision by phone as soon as SELECTCARE makes the decision. Within three calendar days after SELECTCARE tells You of the decision in person or by phone, SELECTCARE will send You a letter that explains the decision. If SELECTCARE does not tell You about the decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If SELECTCARE denies your request for a fast decision, You may file a grievance about this decision, as described in this Section 11.

### **What happens next if SELECTCARE decides completely in your favor?**

If SELECTCARE makes 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:** SELECTCARE must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, SELECTCARE must pay within 60 calendar days.

**2. For a standard decision about medical care:** SELECTCARE 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 SELECTCARE received the request You made for the initial decision. If SELECTCARE extended the time needed to make the decision, SELECTCARE will approve or provide your medical care when SELECTCARE makes the decision.

**3. For a fast decision about medical care:** SELECTCARE 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, SELECTCARE must provide it sooner.

### **What happens next if SELECTCARE denies your request?**

If SELECTCARE denies your request, SELECTCARE may decide completely or only partly against You. For example, if SELECTCARE denies your request for payment for care that You have already received, SELECTCARE may say that SELECTCARE will pay nothing or only part of the amount You requested. In denying a request for medical care, SELECTCARE 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 SELECTCARE to reconsider the decision, as explained below in Step 2.

**STEP 2: If SELECTCARE Denies Part or All of Your Request in Step 1, You May Ask SELECTCARE to Reconsider the Decision. This is Called an “Appeal” or “Request for Reconsideration”.**

Please call SELECTCARE at 1-866-230-2513 or TTY at 1-888-685-8480 if You need help in filing your appeal. You may ask SELECTCARE to reconsider the initial decision made in Step 1, even if only part of the decision is not what You requested. When SELECTCARE receives your request to reconsider the initial decision, SELECTCARE gives the request to different people than those who were involved in making the initial decision. This helps ensure that SELECTCARE 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 made about authorizing medical care, then You and/or your Physician will first need to decide whether You need a “fast” appeal. The procedures for deciding on a “standard” or a “fast” appeal in Step 2 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**

SELECTCARE must gather all the information needed to make a decision about your appeal. 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 Physician’s records or the Physician’s opinion to help support your request. You may need to give the Physician a written request to get information.

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

- In writing, to:

**SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

- By fax, at (713) 843-6740 to the attention of the Appeals Department.
- By telephone -- if it is a “fast” appeal -- at 1-866-230-2513 or TTY at 1-888-685-8480.
- In person, at: 4888 Loop Central Drive, Suite 300, Houston, Texas 77081

You also have the right to ask SELECTCARE for a copy of your file that contains the information regarding your appeal. You can write and ask for a copy of your file at:

**SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

SELECTCARE is 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 the appeal in Step 2 are the same as the rules about who may ask for an “initial decision” in Step 1. Please 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 SELECTCARE 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 SELECTCARE in writing at:

**SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081**

within 60 calendar days after SELECTCARE notifies You of the initial decision from Step 1. SELECTCARE 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 SELECTCARE will delay when SELECTCARE begins the appeal, since this office must forward your appeal request to SELECTCARE.

### **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 SELECTCARE decide on your appeal?**

How quickly SELECTCARE decides on the appeal depends on the type of appeal:

**1. For a decision about payment for care You already received:** After SELECTCARE receives your appeal, SELECTCARE has 60 calendar days to make a decision. If SELECTCARE does 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 SELECTCARE receives your appeal, SELECTCARE has 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 SELECTCARE finds that some information is missing which can help You, SELECTCARE can take up to 14 more calendar days to make the decision. If SELECTCARE does not tell You the 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 SELECTCARE receives your appeal, SELECTCARE has up to 72 hours to make a decision, but will make it sooner if your health requires. However, if You request it, or if SELECTCARE finds that some information is missing which can help You, SELECTCARE can take up to 14 more calendar days to make the decision. If SELECTCARE does not tell You the 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 SELECTCARE decides completely in your favor?**

**1. For a decision about payment for care You already received:** SELECTCARE must pay within 60 calendar days of the day SELECTCARE received your request for SELECTCARE to reconsider the initial decision. If SELECTCARE decides 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:** SELECTCARE 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 SELECTCARE received your appeal. If SELECTCARE extends the time needed to decide your appeal, SELECTCARE will authorize or provide your medical care when SELECTCARE makes the decision.

**3. For a fast decision about medical care:** SELECTCARE 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 SELECTCARE extended the time needed to decide your appeal, SELECTCARE will authorize or provide your medical care at the time SELECTCARE makes the decision.

## **What happens next if SELECTCARE denies your appeal?**

If SELECTCARE denies 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 SELECTCARE. SELECTCARE will tell You in writing that your appeal has been sent to this organization for review. How quickly SELECTCARE 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:** SELECTCARE must send all the information about your appeal to the independent review organization within 60 calendar days from the date SELECTCARE received your appeal in Step 2.
- 2. For a standard decision about medical care:** SELECTCARE 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 SELECTCARE received your appeal in Step 2.
- 3. For a fast decision about medical care:** SELECTCARE must send all of the information about your appeal to the independent review organization within 24 hours of the decision.

**STEP 3: If SELECTCARE Denies 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 SELECTCARE. SELECTCARE will tell You when SELECTCARE has sent your appeal to this organization. You have the right to get a copy from SELECTCARE of your case file that was sent to this organization. SELECTCARE may 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**, SELECTCARE must pay within 30 calendar days after receiving the decision.

**2. For a standard appeal about medical care**, SELECTCARE 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**, SELECTCARE 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 \$ 100.00 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:

- You can send it 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 in Step 4.
- Instead of sending your request directly to the independent review organization that reviewed your appeal in Step 3, You can send it to SELECTCARE, 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 in Step 4.

**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.

The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than \$ 100.00. If the dollar value is less than \$ 100.00, 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:**

SELECTCARE must pay for, authorize, or provide the service You have asked for within 60 calendar days from the date SELECTCARE receives notice of the decision. SELECTCARE has 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 is Reviewed by a Medicare Appeals Council.**

### **This Council will first decide whether to review your case**

If the Medicare Appeals Council decides not to review your case, then either You or SELECTCARE may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is \$ 1,050.00 or more. If the dollar value is less than \$ 1,050.00, 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:**

SELECTCARE must pay for, authorize, or provide the medical service You have asked for within 60 calendar days from the date SELECTCARE receives notice of the decision. However, SELECTCARE has 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 \$ 1,050.00. If the dollar value is less \$ 1,050.00, the Council's decision is final.

### **If the Council decides against You:**

If the amount involved is \$ 1,050.00 or more, You 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 \$ 1,050.00, the Council's decision is final and You may not take the appeal any further.



## **STEP 6: Your Case Goes to a Federal Court.**

If the contested amount is \$ 1,050.00 or more, You or SELECTCARE may ask a Federal Court Judge to review the case.

### **Complaints About Being Discharged From the Hospital Too Soon**

When You are hospitalized, You have the right to get all the Hospital care covered by SELECTCARE that is necessary to diagnose and treat your Sickness or Injury. According to Federal law, the date You leave the Hospital (your “**discharge date**”) must be determined solely by your medical needs. This part of Section 11 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 show You a notice called the **Important Message from Medicare**. This notice explains your rights under the law.

When a Physician decides that You are ready to leave the Hospital (to “be discharged”), You should be given a copy of the notice that includes specific information about your Hospital discharge. It will tell You:

- 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.
- That your doctor or the Hospital may arrange for services You will need after You leave the Hospital.
- Your right to appeal a discharge decision.

### **Review of your Hospital discharge by the Quality Improvement Organization (the QIO)**

If You think that You are being discharged too soon, You must ask your health plan 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 SELECTCARE will stop covering your Hospital stay (stop paying SELECTCARE’s 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 QIO?**

“QIO” stands for Quality Improvement Organization. The QIO is a group of health care professionals who are paid by the Federal Government. They are not part of SELECTCARE or your Hospital. There is one QIO in each state. The name of the QIO differs depending on which state You are in.

### **Getting a QIO review of your Hospital discharge**

If You want to have your discharge reviewed, You must act quickly to contact the QIO. The **Important Message from Medicare** gives the name and telephone number of your QIO and tells You what You must do:

- You must ask the QIO 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 QIO **no later than noon** of the next 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 QIO (see below).

If the QIO reviews your discharge, it will examine your medical information then give an opinion about whether it is medically appropriate for You to be discharged on the date that has been set for You. The QIO will make this decision within one day after it has received all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, You will not be responsible for paying the Hospital charges until noon the day after the QIO gives You its decision.
- If the QIO agrees with You, then SELECTCARE will continue to cover your Hospital stay for as long as Medically Necessary while You are a Member of SELECTCARE.

### **What if You do not ask the QIO for a review by the deadline?**

**You still have another option: asking SELECTCARE for a “fast appeal” of your discharge**

If You do not ask the QIO for a “fast review” (“fast appeal”) of your discharge by the deadline, You can ask SELECTCARE for a “fast appeal” of your discharge. How to ask SELECTCARE for a fast appeal is covered in the first part of this Section 11.

If You ask SELECTCARE 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 received past your discharge date. Whether You have to pay or not depends on the decision SELECTCARE makes:

- If SELECTCARE decides, based on the fast appeal, that You need to stay in the Hospital, SELECTCARE will continue to cover your Hospital care for as long as Medically Necessary.
- However, if SELECTCARE decides that You should not have stayed in the Hospital beyond your discharge date, then SELECTCARE will **not** cover any Hospital care You receive 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 SNF, Home Health Agency or CORF care You receive using Step 1 of the appeals process described in this Section 11.

### **Complaints If You Think Your Coverage for Skilled Nursing Facility (SNF), Home Health Agency or Comprehensive Outpatient Rehabilitation Facility (CORF) Services is Ending Too Soon**

When You are a patient in a SNF, Home Health Agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), You have the right to get all the SNF, HHA or CORF care covered by SELECTCARE that is necessary to diagnose and treat your illness or Injury. The day SELECTCARE ends your SNF, HHA or CORF Coverage is based on when your stay is no longer Medically Necessary. This part of Section 11 explains what to do if You believe that your Coverage is ending too soon.

#### **Information You will receive during your SNF, HHA or CORF stay**

If SELECTCARE decides to end the Coverage for your SNF, HHA, or CORF services, You will get written notice either from SELECTCARE 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 (QIO)**

You have the right by law to ask for an appeal of SELECTCARE’s termination of your Coverage. As will be explained in the notice You get from SELECTCARE or your provider, You can ask the Quality Improvement Organization (the “QIO”) to do an independent review of whether the terminating of 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 QIO. The written notice You got from SELECTCARE or your provider gives the name and telephone number of your QIO and tells You what You must do.

- If You get the notice 2 days before your Coverage ends, You must be sure to make your request **no later than noon** of the day after You get the notice.
- 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 QIO 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 SELECTCARE has given to the QIO. You and the QIO will each get a copy of SELECTCARE's 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 QIO will make this decision within one full day after it receives the information it needs to make a decision.

### **What happens if the QIO decides in your favor?**

If the QIO agrees with You, then SELECTCARE will continue to cover your SNF, HHA or CORF services for as long as Medically Necessary.

### **What happens if the QIO denies your request?**

If the QIO decides that SELECTCARE's decision to terminate Coverage was medically appropriate, You will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice You got from SELECTCARE or your provider. Neither Original Medicare nor SELECTCARE will pay for these services. If You stop receiving services on or before the date given on the notice, You can avoid any financial liability.

### **What if You do not ask the QIO for a review in time?**

### **You still have another option: asking SELECTCARE for a "fast appeal" of your discharge**

If You do not ask the QIO for a "fast appeal" of your discharge by the deadline, You can ask SELECTCARE for a "fast appeal" of your discharge. How to ask for this fast appeal is covered in more detail previously in this Section 11.

If You ask SELECTCARE for a fast appeal of your termination and You continue getting services from the SNF, HHA, 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 SELECTCARE makes.

- If SELECTCARE decides, based on the fast appeal, that You need to continue to get your services covered, then SELECTCARE will continue to cover your care for as long as Medically Necessary.
- If SELECTCARE decides that You should not have continued getting Coverage for your care, then SELECTCARE 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 QIO by noon after the day You are given written notice that SELECTCARE will be terminating Coverage for your SNF, HHA or CORF services, and if You stay in the SNF, HHA or CORF after this date, You run the risk of having to pay for the SNF, HHA or CORF care You receive on and after this date. However, You can appeal any bills for SNF, HHA or CORF care You receive using Step 1 of the appeals process described in this Section 11.

### **Making complaints (called “grievances”) about any other type of problem You have with SELECTCARE or one of the TEXANPLUS Plan providers**

This last part of Section 11 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, problems about being discharged from the Hospital too soon, and problems about Coverage for SNF, HHA, 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 believe that mistakes have been made
- If You feel that You are being encouraged to leave (disenroll from) SELECTCARE
- If You feel that You are being discouraged from seeking the care You think You need
- 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 Physicians, nurses, receptionists, or other staff
- Cleanliness or condition of Physician’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 SELECTCARE’s decision to not give You a “fast appeal” or if SELECTCARE takes an extension on SELECTCARE’s initial decision or appeal. See below for more detail.

### **Filing a grievance with SELECTCARE**

If You have a complaint, SELECTCARE encourages You to first call SELECTCARE at the number on the front of this booklet and on the back of your TEXANPLUS ID. SELECTCARE will try to resolve any complaint that You might have over the phone. If SELECTCARE cannot resolve your complaint over the phone, SELECTCARE has a formal procedure to review your complaints. SELECTCARE calls this the Complaint and Grievance Resolution Process.

If You have an issue or concern regarding the provision of health services or benefits under this EOC which is not related to your Coverage, including payment for care outlined in this Section 11 above, You should contact your Personal Service Specialist at the telephone number or address shown on your TEXANPLUS ID. Issues or concerns, based on a notice giving You the right to file a grievance, must be filed within 60 days from the date of such notice. Other issues or concerns must be filed within 60 days after the event for which You have an issue or concern.

SELECTCARE’s authorized representative will attempt to resolve your complaint (through informal discussions) as soon as possible but within no more than 30 days from your telephone call to SELECTCARE.

If at any time You feel that your problem has not been resolved satisfactorily through informal discussions You may present a formal written grievance to SELECTCARE. This formal written grievance should include your name, address, TEXANPLUS ID number, signature, date and summary of the problem, including a statement of action You are requesting. Your Personal Service Specialist will assist You in preparing and submitting your grievance if You need help.

Upon receipt of a formal written grievance, SELECTCARE will conduct a review of the grievance. SELECTCARE will provide You with a written response of the proposed resolution within 60 days from the date SELECTCARE received the written grievance.

**Grievance Hearing.** If You are not satisfied with SELECTCARE’s resolution of your formal written grievance, You may submit a written request for a grievance hearing stating the facts of the case and the resolution desired within 60 days of receiving SELECTCARE’s response to your written grievance. If You request a hearing, a committee will be appointed by SELECTCARE and will be empowered to resolve or recommend the resolution of the grievance.

The committee will advise You of the date and place of a hearing. The hearing will be held within 30 days following the receipt of the request for a hearing by SELECTCARE. At the hearing, the committee will receive testimony, explanation or other information from You or other persons deemed necessary by the committee for the fair review of the grievance.

You have the right to attend and participate in the hearing process and have the right to be represented by a designated representative of your choice. The committee will review your testimony, explanation or other information and advise You, in writing, of its findings within 14 days of the conclusion of the hearing. You also have the right to file a complaint with the Office of the Commissioner of Insurance, Texas Department of Insurance.

**For quality of care problems, You may also complain to an outside agency called 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 QIO. “**QIO**” stands for Quality Improvement Organization. The QIO is a group of Physicians and other health care professionals who are paid by the Federal Government. They are not connected to SELECTCARE or your Hospital. There is one QIO in each state. If You are concerned about the quality of the care You have received, You may also file a complaint with the local Quality Improvement Organization at **Texas Medical Foundation, 901 Mopac Expressway South, Barton Oaks Plaza Two Suite 2000, Austin, TX 78746, or call them at 1-800-725-8315.** Quality Improvement Organizations are entities paid by CMS to review Medical Necessity, access to care, appropriateness, and quality of certain medical care and services provided to Medicare Beneficiaries by practicing Physicians and other health care professionals. The Quality Improvement Organization review process is designed to help stop any improper practices.

## **IMMEDIATE REVIEW OF HOSPITAL DISCHARGE DECISIONS**

**Section 11.1 Notice of Discharge and Medicare Appeals Rights.** You have the right to receive all the Hospital care that is Medically Necessary for the proper diagnosis and treatment of your Sickness or Injury. If You are hospitalized, your discharge date must be determined solely by your medical need. The Hospital or SELECTCARE will give You a written notice of explanation of your rights in connection with a Hospital discharge.

The notice will state the date and reason your Physician has determined that inpatient Hospital Confinement is no longer Medically Necessary. It will also state that You will be financially liable for all costs of care if You remain in the Hospital beyond the date specified. It will also inform You of your appeal rights. If You do not agree with the discharge decision and think that You are being discharged too soon, You have the right to request an immediate review of the discharge decision by a Quality Improvement Organization (QIO). Quality Improvement Organizations are entities paid by CMS to review Medical Necessity, access to care, appropriateness, and quality of certain medical care and services provided to Medicare Beneficiaries by practicing Physicians and other health care professionals. The phone number and address of the QIO for your area will be stated in the notice. **Remember:** If You remain in the Hospital beyond your discharge date and You did not request a QIO review, You will be responsible for payment for all services beginning on the date specified in the notice.

**Section 11.2 Request For QIO Review.** If You disagree with your Hospital discharge decision:

- You must make your request for review to the QIO in writing or by telephone by noon of the first working day after You receive notice that your Physician has determined that the Hospital stay is no longer necessary.
- The QIO must ask You for your views about your case before making its decision. The QIO will inform You by phone or in writing of its decision on the review. The QIO 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 QIO agrees with the discharge decision, You may be billed for all costs of your Hospital Confinement beginning at noon of the day **after** You receive the QIO's decision.
- The QIO 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.
- You will not be responsible for the cost of Hospital care before You receive the QIO's decision.

**NOTE:** The process described above is called "immediate review". If You miss the deadline for this immediate review while You are in the Hospital, You may still request a review of the decision to no longer pay for your care at any point during your Hospital Confinement or after You have left the Hospital by following the Standard Appeal Process described in Section 11 or the Expedited Appeal Process (Reconsideration) described in Section 11 of this EOC.

If You ask for immediate review by the QIO, You will be entitled to the immediate review process **instead** of the Standard Appeal Process described in Section 11 or the Expedited Appeal Process (Reconsideration) described in Section 11 of this EOC. The advantage of the QIO review is that You will get the results within three days if You request a QIO review by the deadline. Also, You are not financially liable for Hospital charges during the QIO review. However, You may be financially liable for Hospital charges during the Standard Appeal Process or the Expedited Appeal Process.



## **SECTION 12 GENERAL PROVISIONS**

**Section 12.1 Entire EOC.** This EOC and any Amendments to it and your Application shall constitute the entire Member's contract with SELECTCARE. All statements made by You will, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under this EOC or be used in defense of a legal action unless it is contained in a written Application. It is acknowledged and agree that You are relying on the representation and warranties as set forth herein this EOC and not on any other written or verbal statements to the contrary.

**Section 12.2 Limitation of Action.** You or any other complainant are required by federal regulations to complete the Medicare Appeals Process described in Section 11 of this EOC before bringing any legal proceeding or other action. You are also required under this EOC to follow SELECTCARE's established Complaint and Grievance Resolution Process described in Section 11 for all other complaints. Even if the complainant has completed the applicable complaint resolution procedure and has exhausted all administrative procedures or remedies, any legal proceeding or action must be brought within 3 years from the date the cause of action first arose or You forfeit your rights to bring any action against SELECTCARE. Exceptions to this limitation of action are: (a) the reimbursement of Eligible Expenses as set forth in Section 9 of this EOC (subject to the limitation of action provision set forth in that section), and (b) the timeframes set forth in Section 11 that apply to the Medicare Appeals Process.

**Section 12.3 Assignment of Rights.** No rights under this EOC are assignable by any Member. Any such attempted assignment will be void.

**Section 12.4 Amendments and Alterations.** Amendments to this EOC are effective upon 30 days written notice to You. No change will be made to this EOC without the prior approval of SELECTCARE and Group. Any change will be made by an Amendment that is signed by an officer of SELECTCARE and/or your Employer, as applicable. No other agent has authority to change this EOC or to waive any of its provisions.

**Section 12.5 Relationships Between Parties.** The relationships between SELECTCARE and Contracted providers and between SELECTCARE and You are **solely** contractual relationships between independent contractors. Neither You nor any Contracted providers are agents or employees of SELECTCARE, nor is SELECTCARE or any employee of SELECTCARE an agent or employee of Contracted providers.

The relationship between a Contracted provider and You is that of provider and patient. The Contracted provider is solely responsible for the services provided to any Member. You are not an agent or employee of SELECTCARE and cannot, for example, make any changes to or interpretations of Coverage under TEXANPLUS. SELECTCARE reserves the right to make decisions concerning whether those services are Covered Health Services.

**Section 12.6 Records.** You will furnish SELECTCARE with all information and records, which SELECTCARE may reasonably require with regard to any matters pertaining to this EOC.

Accepting Coverage means that You authorize and direct any person or institution that has provided health services to You, to furnish SELECTCARE with any and all information and

records or copies of records relating to the services provided to You. These records must be furnished to SELECTCARE at any reasonable time upon its request. Also by accepting Coverage, You authorize and direct SELECTCARE and any person or institution to provide your Primary Care Physician all information and records relating to the services provided to You to coordinate your care and maintain a central medical record for You.

SELECTCARE agrees that such information, communications and records pertaining to your care will be considered confidential. You have the right to access your medical records. SELECTCARE and Contracted providers will provide timely access to your records and any information that pertains to them. SELECTCARE and any of its designees has the right to release any and all records concerning health services which are necessary to implement and administer the terms of this EOC or for appropriate medical review or quality assessment. Written permission from You or your authorized representative will be obtained before medical records can be released to any third party not directly concerned with your care or responsible for performing administrative functions relating to this EOC. SELECTCARE or Contracted providers are permitted to charge You reasonable fees to cover costs for completing requested medical abstracts or forms.

In some cases, SELECTCARE will designate other persons or entities to request records or information for or related to You and to release these records as necessary. SELECTCARE's designees have the same rights to this information, as does SELECTCARE.

By accepting Coverage, You authorize SELECTCARE and its related entities to use and transfer the information gathered under this EOC for research and analytic purposes during and after the term of this EOC.

**Section 12.7 Clerical Error.** A clerical error will not deprive You of Coverage nor create a right to benefits not covered under this EOC.

**Section 12.8 Notice.** Written notice given by SELECTCARE to You at the last address provided to SELECTCARE by You shall be deemed notice to You. It is your responsibility to provide timely notice to SELECTCARE of address changes.

**Section 12.9 Covered Benefits.** In no event will You be responsible to pay for benefits received in accordance with this EOC except as otherwise provided in this EOC. You are not liable for any sums owed by SELECTCARE to any provider. You will be indemnified by SELECTCARE for any fees that You have paid that are the legal obligation of SELECTCARE.

**Section 12.10 Workers' Compensation Not Affected.** The Coverage provided under this EOC does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

**Section 12.11 Conformity with Statutes.** Any provision of this EOC which, on its effective date, is in conflict with the requirements of federal statutes and regulations, or the applicable statutes and regulations of the jurisdiction in which it is delivered to the extent not preempted by federal law, is hereby amended to conform to the full requirements of such statutes and regulations. CMS reviews and approves each Medicare Advantage Plan to ensure the Medicare Advantage Organization does not (a) promote discrimination; (b) discourage enrollment; (c) steer specific subsets of Medicare beneficiaries to particular Medicare

Advantage Plans; or (d) inhibit access to services. SELECTCARE agrees to adhere to these policies and procedures and will appropriately monitor operations to comply with these requirements.

**Section 12.12 Examination of Members.** In the event of a question or dispute concerning Covered Health Services, SELECTCARE may reasonably require that a Member be examined at SELECTCARE's expense by a Contracted Physician acceptable to SELECTCARE. An example of this Examination of Members is the Second Opinion Policy set forth in Section 6.



## Value-Added Items and Services

SELECTCARE provides You access to discounts for dental and hearing care as a Value-Added service. You will receive value and convenience for the services You're most likely to use. SelectCare understands the importance of maintaining oral and hearing health and therefore has partnered with CAREINGTON International to provide You a dental and hearing discount program. CAREINGTON provides an extensive network of qualified professionals and exceptional savings on dental and hearing services.

### Hearing Discount Services:

- Provided by HearPO, the largest provider of audiology and hearing aid services in the United States.
- Save 30% on hearing exams and services.
- Save up to 62% on all hearing aids at any HearPO participating provider.
- Receive discounts on repairs and batteries.
- Access to the newest programmable and digital technology.
- Schedule an appointment by calling 1-888-HEARING.
- Locate a hearing provider at 1-800-456-6801.

### Dental Discount Services:

- Receive between 20% - 50% off most dental procedures.
- Up to 20% discount on specialty services
- Cosmetic dentistry and teeth whitening included
- 24,000 participating providers
- Locate a dental provider at 1-800-290-0523

### Eldercare Services:

#### Nurse Navigator

Works with You to identify elder care needs, evaluate options, put solutions in place and provide ongoing support needed to maintain independence and quality of life. Includes:

- Wellness assessments;
- Care planning tools;
- 24-hour Nurse Navigator elder care advisor; and
- Significant discounts on senior housing alternatives and additional care services.

Limitations: CAREINGTON cannot guarantee specialty care in all locations. Cases in which You are referred to a participating specialist, You will generally receive 20% off their usual and customary fees. Please verify such benefits with each individual provider. Work in progress, after enrollment in the dental plan, must be completed by the Dentist who started the work. Any dental procedures performed by a non-participating Dentist are not covered. CAREINGTON cannot guarantee the continued participation of any Dentist. Not all types of Dentists may be available in your area. Some providers may charge for missed or broken appointments without prior notice. It is the Member's responsibility to verify that the Dentist is a participating provider. This does not cover all procedures which might be provided by a general

Dentist. Any procedure rendered that is not listed on the Schedule of Services may cause additional cost to be incurred by the Member.

These Value-Added services are offered by SELECTCARE under the following conditions: (1) these programs are not offered under our contract with Medicare, but are available to all enrollees who are members of SELECTCARE and TexanPlus; (2) these programs are not subject to the Medicare appeals process. Any disputes regarding these programs may be subject to the SELECTCARE grievance process; and (3) should a problem arise with this program, please call SELECTCARE and TexanPlus for assistance at (866)230-2513 (TTY (888) 685-8480. Our customer service hours are Monday through Friday, between 9 a.m. and 5 p.m. CST. These discount programs will be available for the entire contract year.



SelectCare of Texas, LLC  
4888 Loop Central Drive, Suite 300  
Houston, Texas 77081

ADDRESS SERVICE REQUESTED