

**TEXAS HEALTHSPRING I, LLC**

56840

**GROUP APPLICATION**

050136

- Entire Agreement:** This Group Application, including the Evidence of Coverage, Summary of Benefits, any Supplemental Benefits, and any Exhibits, Amendments, endorsements, inserts or attachments, herein defined as ("Agreement") constitutes the entire Agreement between the City of Houston ("Group") and Texas HealthSpring I, LLC, a Texas limited liability company licensed as a health maintenance organization ("HMO"), and on the Effective Date of Coverage, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by HMO for Covered Services provided under this Agreement. Exhibit I, Additional Terms and Conditions, Exhibit II Premium Rates, Exhibit IIA Rate Renewal Calculation Formula, Exhibit III Evidence of Coverage and Summary of Benefits, and Exhibit IV Texas HealthSpring Formulary and Excluded Drug Listing are attached hereto and are incorporated in their entirety herein.
- Governmental Approval:** The provisions of this entire Agreement must be filed with the Centers for Medicare and Medicaid Services ("CMS") after its approval by the Group and prior to the distribution of any of the terms hereof, including the provisions contained in the Evidence of Coverage and Summary of Benefits and all documents incorporated therein, to persons eligible for Coverage under the Plan. HMO may be required to revise such terms and provisions to obtain CMS's approval or to comply with Federal law and regulation, and Group agrees to such changes subject to the prior written approval of Group's Human Resources Director.
- Group:** City of Houston
- HMO Benefit Level:** Plan: Group Specific Evidence of Coverage and Summary of Benefits
- Group Agreement Effective Date:** May 1, 2005
- Term of Group Agreement:** The initial term shall be: From May 1, 2005 to December 31, 2005. Thereafter, renewals shall be in accordance with the terms and conditions of Exhibit II.
- HMO Premium Rates:** For Premium Rates see Exhibit II attached hereto and incorporated in its entirety herein.
- Premium Due Dates:** The Group Agreement Effective Date and the 1<sup>st</sup> day of each succeeding calendar month. Premium due date shall be subject to a thirty (30) day grace period.

**Notices :**

Written notice shall be given by certified U.S. Mail, return receipt requested, postage prepaid, to HMO at:

**TEXAS HEALTHSPRING I, LLC**

2900 North Loop West, Suite 1300  
Houston, Texas 77092  
(832) 553-3300

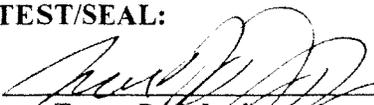
And to Group at:

**CITY OF HOUSTON**

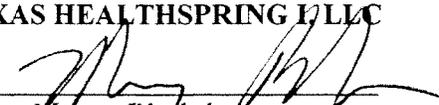
Human Resources Director  
611 Walker, Suite 4A  
Houston, Texas 77002

IN WITNESS WHEREOF, and as duly authorized, the parties hereto execute this Agreement in duplicate with the Effective Date herein provided.

**ATTEST/SEAL:**

By:   
Name: Teresa R. J. Jordan  
Title: Assistant Secretary

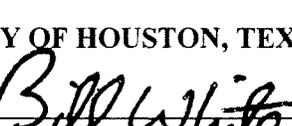
**TEXAS HEALTHSPRING I/LLC**

By:   
Name: Murray Blackshear  
Title: President

**ATTEST/SEAL:**

By:   
City Secretary

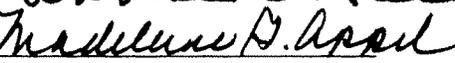
**CITY OF HOUSTON, TEXAS**

By:    
Mayor

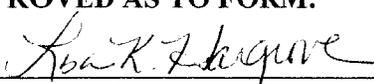
**APPROVED:**

By:   
Group's Human Resources Director

**COUNTERSIGNED**

  
By:   
City Controller

**APPROVED AS TO FORM:**

By:   
Sr. Assistant City Attorney  
L.D. File No.

**DATE COUNTERSIGNED**

April 15, 2005

## EXHIBIT I TO GROUP APPLICATION

### **Additional Terms and Conditions**

- A. Compliance With Equal Employment Opportunity Ordinance. HMO shall comply with all provisions of the City's Equal Employment Opportunity Ordinance as set out in Exhibit A.
- B. Minority and Women Business Enterprises. HMO agrees to use its best efforts to carry out the policy of the Group with regard to minority and women business enterprises as set out in Exhibit B.
- C. Allocation and Appropriation of Funds by the Group. HMO agrees to the terms and conditions set out in Exhibit C regarding the Group's allocation and appropriation of funds to pay HMO under this Agreement.
- D. Service Performance Standards. HMO agrees to meet the service performance criteria set out in Exhibit D.
- E. Management Reports. HMO will provide the management reports that are listed in Exhibit E to the Group at such times as are mutually agreed upon between the Group and HMO.
- F. Supplemental Terms & Conditions. HMO and Group agree to be bound by all applicable supplemental terms and conditions set forth in Exhibit F.

## EXHIBIT "A"

### EQUAL EMPLOYMENT OPPORTUNITY

1. The contractor\*, subcontractor, vendor, supplier, or lessee will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, or age. The contractor, subcontractor, vendor, supplier, or lessee will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, sex, national origin, or age. Such action will include, but not be limited to, the following: employment; upgrading; demotion or transfer; recruitment advertising; layoff or termination; rates of pay or other forms of compensation and selection for training, including apprenticeship. The contractor, subcontractor, vendor, supplier or lessee agrees to post in conspicuous places available to employees, and applicants for employment, notices to be provided by the City setting forth the provisions of this Equal Employment Opportunity Clause.
2. The contractor, subcontractor, vendor, supplier, or lessee states that all qualified applicants will receive consideration for employment without regard to race, religion, color, sex, national origin or age.
3. The contractor, subcontractor, vendor, supplier, or lessee will send to each labor union or representatives of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the agency contracting officer advising the said labor union or worker's representative of the contractor's and subcontractor's commitments under Section 202 of Executive Order No. 11246, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
4. The contractor, subcontractor, vendor, supplier, or lessee will comply with all provisions of Executive Order No. 11246 and the rules, regulations, and relevant orders of the Secretary of Labor or other Federal Agency responsible for enforcement of the equal employment opportunity and affirmative action provisions applicable and will likewise furnish all information and reports required by the Mayor and/or Contractor Compliance Officer(s) for purposes of investigation to ascertain and effect compliance with this program.
5. The contractor, subcontractor, vendor, supplier, or lessee will furnish all information and reports required by Executive Order No. 11246, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to all books, records, and accounts by the appropriate City and Federal Officials for purposes of investigations to ascertain compliance with such rules, regulations, and orders. Compliance reports filed at such times as directed shall contain information as to the employment practice policies, program, and work force statistics of the contractor, subcontractor, vendor, supplier, or lessee.
6. In the event of the contractor's, subcontractor's, vendor's, supplier's, or lessee's noncompliance with the non-discrimination clause of this contract or with any of such rules, regulations, or orders, this contract may be canceled, terminated, or suspended in whole or in part, and the contractor, subcontractor, vendor, supplier, or lessee may be declared ineligible for further City contracts in accordance with procedures provided in Executive Order No. 11246, and such other sanctions may be imposed and remedies invoked as provided in the said Executive Order, or by rule, regulation, or order of the Secretary of Labor, or as may otherwise be provided by law.
7. The contractor shall include the provisions of paragraphs 1-8 of this Equal Employment Opportunity Clause in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontractor or purchase order as the contracting agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event the contractor becomes involved in, or is threatened with litigation with a subcontractor or vendor as a result of such direction by the contracting agency, the contractor may request the United States to enter into such litigation to protect the interests of the United States.

8. The contractor shall file and shall cause his or her subcontractors, if any, to file compliance reports with the City in the form and to the extent as may be prescribed by the Mayor. Compliance reports filed at such times as directed shall contain information as to the practices, policies, programs, and employment policies and employment statistics of the contractor and each subcontractor.

\* For purposes of this Exhibit "A", Contractor shall be used instead of HMO.

## EXHIBIT "B"

### Minority and Women Business Enterprises – HMO

It is the City's policy to ensure that Minority and Women Business Enterprises ("MWBEs") have the full opportunity to compete for and participate in City contracts. The objectives of Chapter 15, Article V of the City of Houston Code of Ordinances, relating to City-wide Percentage Goals for contracting with MWBEs, are incorporated into this Agreement.

HMO shall make good faith efforts to award subcontracts or supply agreements in at least an amount equal to ten percent (10%) of the medical costs incurred under the HMO (which costs can include IPAs, pharmacies, DME providers, home health facilities, clinics, and other related firms), excluding taxes, Hospital charges and outpatient surgery facility charges. The City's policy does not require HMO to in fact meet or exceed this goal, but it does require HMO to objectively demonstrate that it has made good faith efforts to do so. To this end, HMO shall maintain records showing

- (1) subcontracts and supply agreements with Minority Business Enterprises,
- (2) subcontracts and supply agreements with Women's Business Enterprises, and
- (3) specific efforts to identify and award subcontracts and supply agreements to MWBE.

HMO shall submit periodic reports of its efforts under this Section to the Affirmative Action Director in the form and at the times he or she prescribes.

HMO shall require written subcontracts with all MWBE subcontractors and suppliers and shall submit all disputes with MWBE subcontractors to binding arbitration if directed to do so by the Affirmative Action Director. All agreements must contain the terms set out in Exhibit "B-1."

In addition to the above MWBE goal, the City has a strong commitment to offering its employees a diverse Provider network. The City will monitor the Provider network to ensure that it represents a cross section of the community and that at least thirty percent (30%) of the physicians are minority and/or female.

## EXHIBIT "B-1"

### MWBE SUBCONTRACT TERMS

HMO shall ensure that all subcontracts with MWBE subcontractors and suppliers are clearly labeled **"THIS AGREEMENT IS SUBJECT TO BINDING ARBITRATION ACCORDING TO THE TEXAS GENERAL ARBITRATION ACT"** and contain the following terms:

1. (MWBE subcontractor) shall not delegate or subcontract more than 50% of the work under this subcontract to any other subcontractor or supplier without the express written consent of the City of Houston's Affirmative Action Director ("the Director").
2. (MWBE subcontractor) shall permit representatives of the City of Houston, at all reasonable times, to perform (1) audits of subcontractor's books and records, and (2) inspections of all places where work is to be undertaken in connection with this subcontract. Subcontractor shall keep its books and records available for inspection for at least 4 years after the end of its performance under this subcontract. Nothing in this provision shall change the time for bringing a cause of action.
3. Within 5 business days of execution of this subcontract, HMO (prime contractor) and Subcontractor shall designate in writing to the Director an agent for receiving any notice required or permitted to be given under Chapter 15 of the Houston City Code of Ordinances, along with the street and mailing address and phone number of the agent.
4. Any controversy between the parties involving the construction or application of any of the terms, covenants, or conditions of this subcontract must, upon the written request of one party served upon the other or upon notice by the Director served on both parties, be submitted to binding arbitration, under the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code Ann., Ch. 171 -- "the Act"). Arbitration must be conducted according to the following procedures:
  - ◆ a. Upon the decision of the Director or upon written notice to the Director from either party that a dispute has arisen, the Director shall notify all parties that they must resolve the dispute within 30 days or the matter may be referred to arbitration.
  - ◆ b. If the dispute is not resolved within the time specified, any party or the Director may submit the matter to arbitration conducted by the American Arbitration Association under the rules of the American Arbitration Association, except as otherwise required by the City's contract with the American Arbitration Association on file in the City's Affirmative Action Division Office.
  - ◆ c. Each party shall pay all fees required by the American Arbitration Association and sign a form releasing the American Arbitration Association and its arbitrators from liability for decisions reached in the arbitration.
  - ◆ d. If the American Arbitration Association no longer administers Affirmative Action arbitration for the City, the Director shall prescribe alternate procedures to provide arbitration by neutrals in accordance with the requirements of Chapter 15 of the Houston City Code of Ordinances.

**EXHIBIT "C"**

**HMO Limit of Appropriation**

- ◆ (1) The City's duty to pay money to HMO under this Agreement is limited in its entirety by the provisions of this Section.
- ◆ (2) In order to comply with Article II, Sections 19 and 19a of the City's Charter and Article XI, Section 5 of the Texas Constitution, the City has appropriated and allocated the sum of \$ 21, 000.00 to pay money due under this Agreement (the "Original Allocation") for May and June 2005. The executive and legislative officers of the City, in their discretion, may allocate supplemental funds for this Agreement, but they are not obligated to do so. Therefore, the parties have agreed to the following procedures and remedies:
- ◆ (3) The City Council hereby approves a supplemental allocation by sending a notice signed by the Group's Human Resources Director and the Controller in substantially the following form:

**"NOTICE OF SUPPLEMENTAL ALLOCATION OF FUNDS"**

TO: [Name of HMO]  
FROM: City of Houston, Texas (the "City")  
DATE: [Date of notice]  
SUBJECT: Supplemental allocation of funds for the purpose of the "[title of this Agreement]" between the City and (name of HMO) countersigned by the City Controller on (Date of Countersignature) (the "Agreement").

I, (name of City Controller), City Controller of the City of Houston, certify that the supplemental sum of \$\_\_\_\_\_, upon the request of the below-signed Director, has been allocated for the purposes of the Agreement out of funds appropriated for this purpose by the City Council of the City of Houston. This supplemental allocation has been charged to such appropriation.

The aggregate of all sums allocated for the purpose of such Contract, including the Original Allocation, and all supplemental allocations (including this one), as of the date of this notice, is\$\_\_\_\_\_.

SIGNED:

(Signature of the City Controller)  
City Controller of the City

REQUESTED:

(Signature of the Director)Director

(4) The Original Allocation plus all supplemental allocations are the Allocated Funds. The City shall never be obligated to pay any money under this Agreement in excess of the Allocated Funds. HMO must assure itself that sufficient allocations have been made to pay for services it provides. If Allocated Funds are exhausted, HMO's only remedy is suspension or termination of its performance under this Agreement, and it has no other remedy in law or in equity against the City and no right to damages of any kind.

## EXHIBIT D

### SERVICE PERFORMANCE STANDARDS

The Service Performance Standards described herein shall apply to the Agreement between HMO and Group to which this Exhibit D is attached. The Service Performance Standards set out in this Exhibit D are limited solely to the medical benefit Coverage under HMO and do not include the following: prescription drug; hearing; vision; alternative health services; silver sneakers; or other supplemental services, if applicable, under the medical management programs provided by HMO when elected by the Group.

#### SECTION I DEFINITIONS

**Average Speed to Answer or Wait Time in Queue** means the time the Member spends on hold after being placed in queue.

**Claim Processing Accuracy** means the accuracy rate achieved by HMO in processing claims in accordance with the provisions of a group's medical benefit Coverage administered by HMO.

**Claim Turnaround Time** means the processing time for *Measurable Claims*.

**Health Management** means wellness/disease management programs that are designed to improve the health status of Members. The two standard health management programs include diabetes and congestive heart failure.

**Measurable Claims** means notification on a form acceptable to HMO that a service has been rendered or furnished to a Member in accordance with the provisions of the Group's medical benefit Coverage in effect on the date a service is rendered or furnished. This notification must set forth the full details of such service including, but not limited to, the Member's name; age; sex; Subscriber identification number and group number. Notification must also provide the name and address of the provider of service, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis, and the fee for such service.

Such claim is *measurable* if, when received by HMO, it contains all of the information required to process the claim. If any additional information is required to process the claim, including medical records or supporting documentation, the claim is not considered a *Measurable Claim*.

**Settlement Period** means the period for which HMO's service performance will be measured, as set forth in Addendum D-1.

#### SECTION II SERVICE PERFORMANCE STANDARDS

1. The Service Performance Standards set out in this Exhibit D and Addendum D-1 are limited solely to Fee-for-Service claims paid directly by HMO or Renaissance Physician Organization, HMO's primary delegated entity. Service Performance Standards do not apply to capitation payments paid by HMO or delegated entity.

2. The Service Performance Standards set out in this Exhibit D and Addendum D-1 are limited solely to the HMO medical benefit Coverage under HMO and do not include prescription drug, vision, hearing Coverage or other supplemental benefits.

3. All obligations, terms, conditions, promises, agreements, and language in the Agreement apply equally to the obligations, terms, conditions, promises, agreements, and language in this Exhibit D and Addendum D-1.

## SECTION III CALCULATION

1. In measuring HMO's service performance, percentage levels of performance will be rounded to the nearest tenth of one percent.
2. All measurement and calculation methods used in determining performance results are in accordance with the performance reporting guidelines and/or HMO's corporate policies. Highlights of those guidelines are as follows:

### *Access to Care*

The percentage indicated in Addendum D-1 of all In-Network Health Care Providers who schedule office visits during the preceding calendar year according to the following time frames:

- ◆ Routine office visits scheduled within thirty (30) calendar days of the Member's request for an appointment.
- ◆ Non-urgent, symptomatic office visits within five (5) business days of the Member's request for an appointment.
- ◆ Urgent care visits within two (2) business days of the Member's request for an appointment.

The standard will be measured using the results from the Physician Office Reviews periodically conducted by HMO.

### *Average Speed to Answer*

The *Average Speed to Answer* is the telephone response time that is measured from the time calls are put in queue until they reach their final destination and are answered by a customer service representative. The *Average Speed to Answer* is provided by telephone reports, which compute the average number of seconds that Members spend on hold waiting for their call to be answered.

### *Claim Processing Accuracy*

*Claim Processing Accuracy* is determined from an audit of randomly selected claims. The *Claim Processing Accuracy* percentage is calculated dividing the number of accurately processed claims by the number of claims selected in the sample. All claim data fields are reviewed; however, only errors resulting in a payment error (overpayment or underpayment) are counted as processing errors. Also included are misapplied deductibles and co-share amounts.

Claims excluded as errors are claims with administrative inaccuracies that do not impact claims disposition, future claims disposition, or customer reporting.

### *Claim Turnaround Time*

The Claim Turnaround Time is the processing time for Measurable Claims and is measured from the time the claims are received in an HMO office to the finalization date. The number of days during which claims are held for any reason beyond the control of HMO (for example, if HMO is waiting on the Group to provide Membership and eligibility information) is excluded from the processing cycle time.

### *Member Satisfaction*

The percent of Member satisfaction will be measured based on all respondents to the HMO Member Satisfaction Survey who rate the overall performance of HMO. The standard will be

measured based on the % of satisfaction of all City of Houston respondents. The Member satisfaction survey measures all aspects of a Member's experience including medical services, provider network, claims, customer service, communication, and Plan documents.

#### **SECTION IV TIMING**

1. The Service Performance Standards in this Agreement shall be measured on an annual basis as defined in the Settlement Periods in Addendum D-1.
2. Unless stated otherwise in this SECTION IV, the only period in which HMO's service performance will be measured and for which the Group may receive a refund is on an annual basis.
3. Any claims incurred before May 1, 2005 and any inquiries related to such claims will be excluded from the measurement of HMO's service performance and the Group's refund based thereon for settlement periods set forth in Addendum D-1.
4. For measurement of the Service Performance Standards to continue, Premiums must be received by HMO in accordance with the terms detailed in the Agreement.
5. If for any reason the Agreement is terminated prior to the end of any Settlement Period, HMO's service performance will not be measured and the Group will not receive any refund based on that part of the Settlement Period in which the Agreement was in effect.

#### **SECTION V DETERMINATION**

1. HMO will measure its service performance and report the measurements in accordance with this Exhibit D and Addendum D-1 to Group within ninety (90) days following the end of each Settlement Period. HMO shall refund to the Group any amounts due in accordance with this Exhibit D and Addendum D-1 in the form of an offset against Premium, in one lump sum within 90 days following the applicable Settlement Period. However, if the Agreement has been terminated or is at the end of its term, HMO will repay the amount in a lump sum within five (5) months following the end of the applicable Settlement Period.
2. HMO will be obligated to measure its service performance but will not be obligated to refund the Group based thereon until the Agreement has been executed and is on file with HMO.
3. HMO will not be obligated to measure its service performance and will not be obligated to refund the Group or provide reporting as set forth on Exhibit E based thereon for any portion of Settlement Period in which the Group:
  - a. Fails to provide HMO with timely changes in enrollment or Membership information or any other reports or information as may be necessary for HMO to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of Retirees and Dependents covered under HMO, or
  - b. Fails to pay Premiums in accordance with the terms in the Agreement,
  - c. Membership falls below a threshold of 600 enrolled City of Houston total Members.
4. If for any reason there is a significant change in the benefit structure or the administrative procedures of the HMO Coverage offered by HMO during any Settlement Period, HMO reserves the right to modify the level of performance and/or the Premiums at risk in this Exhibit D and Addendum D-1.

5. HMO will not be obligated to measure any Service Performance Standard impacted by changes requested in writing by the Group during the time period required to modify the HMO system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or Amendments must be submitted to HMO in accordance with the notice provisions of the Agreement.

22. If either party desires to utilize an outside auditing firm to perform an audit, both parties must mutually agree as to the selection of such audit firm. The audit will be performed at the expense of whichever party has requested the outside auditing firm. If HMO does not approve the outside auditing firm requested by the Group, HMO may elect to require the Group to use HMO's designated Public Accounting firm to perform the audit at the Group's expense. All such audits by outside auditing firms shall be subject to HMO's external review procedures and guidelines in existence at the time such audit is performed, a copy of which shall be furnished to the Group, upon request, prior to the commencement of any audit.

SERVICE	DEFINITION	LEVEL OF PERFORMANCE	PREMIUM AT RISK
<b>Member Satisfaction</b>			
1. Member satisfaction	HMO will measure Member satisfaction on an annual basis through a survey sent to all Members. The content and format of the survey shall be mutually agreed between Group and HMO. The City of Houston will be copied on the results of the survey. The standard will be measured based on the % of satisfaction of all City of Houston respondents. The Member satisfaction survey measures all aspects of a Member's experience including medical services, provider network, claims, customer service, communication, and Plan documents.	85 – 100% <85%	\$0 1% of Premium as set forth on Exhibit II
<b>Access to Care</b>			
2. Access to Routine Care	Percent of providers who are able to see patients for routine care within (30) business days.	90%-100% <90%	\$0 1% of Premium as set forth on Exhibit II
3. Access to Non-Urgent Care	Percent of providers who are able to see patients for non-urgent (symptomatic) care within (5) business days.	90%-100% <90%	\$0 1% of Premium as set forth on Exhibit II
4. Access to Urgent Care	Percent of providers who are able to see patients for urgent (serious but non life threatening) care within (2) business days.	90%-100% <90%	\$0 1% of Premium as set forth on Exhibit II
<b>Customer Service</b>			
5. Speed of Answer	Percent of calls that will be answered within (30) seconds	95%-100% <95%	\$0 1% of Premium as set forth on Exhibit II
6. Abandoned Calls	Percent of calls that are abandoned. An abandoned call is defined as a call, calculated over the complete workday, that reaches the facility and is placed in a queue, but is not answered due to the caller hanging up before a service representative becomes available. Any calls terminated by the caller prior to the average	<5% >5%	\$0 1% of Premium as set forth on Exhibit II

	Speed of Answer standard will not be counted as an abandoned call. Performance will be measured based on all business related calls received in the Houston office.		
<b>Health Management</b>			
7. Disease Management	HMO agrees to utilize a comprehensive and multi faceted disease management program to reduce institutional costs for Members with congestive heart failure (CHF) by 10% based on a year two over year one comparison.	>10% <10%	\$0 1% of Premium as set forth on Exhibit II
<b>ID Cards</b>			
8. ID Card Issuance	Percent of ID Cards that will be mailed within 5 to 7 days after receipt of the Application from Group.	98-100% <98%	\$0 1% of Premium as set forth on Exhibit II
<b>Claims Processing</b>			
9. Financial & Procedural Accuracy	Percentage of claims processed accurately (financially and procedurally)	95-100% <95%	\$0 1% of Premium as set forth on Exhibit II
10. Turnaround Time	Percent of claims processed within 14 days, measured from date of claim receipt to finalization date	97-100% <97%	\$0 1% of Premium as set forth on Exhibit II
<b>Total Premium at Risk For Performance Standards</b>			<b>10% of Premium as set forth in Exhibit II</b>

The foregoing is subject to all of the following terms and conditions:

1. HMO's performance under the service performance standards will be reported by HMO at the end of each quarter and Settlement Period, within ninety (90) days after the end of the applicable quarter or Settlement Period. Performance under each standard will be considered separately.
2. If HMO is found to be in material breach of a standard, HMO agrees to repay the amount at risk that is allocated to that standard, in the form of an offset against Premium, in 1 lump sum payment at the end of the applicable settlement period. However, if the Agreement has been terminated or is at the end of its term, HMO will repay the amount in a lump sum within five (5) months following the end of the applicable Settlement Period.
3. Repayment of the amounts specified herein shall not be the City of Houston's sole remedy in the event that HMO materially breaches one or more of the service performance standards and shall not prejudice the City against termination for cause as provided for in the Agreement.
4. All performance results calculated as a percentage will be rounded to the nearest one-tenth (1/10<sup>th</sup>) of 1 percent. If the second decimal numeral is five (5) or greater, then the first decimal numeral will increase by 1. If the second decimal numeral is four (4) or less, the first decimal numeral shall remain unchanged.

For example: 0.25 shall be rounded to 0.3; and  
0.24 shall be rounded to 0.2

**EXHIBIT E**  
**HMO MANAGEMENT REPORTS**

HMO shall provide the following reports to Group. Such reports will provide data necessary for Group to analyze their medical costs (professional and institutional), prescription costs, catastrophic costs, disease management effectiveness as well as cost analysis by provider specialty. In addition, HMO can devise and develop various Management reports as requested by the Group.

**Monthly:**

- ◆ Per Member Per Month Professional Costs by Provider Specialty Report
- ◆ Per Member Per Month Institutional Costs by Institutional Service Category Report
- ◆ Catastrophic Claim Report (de-identified Member listing)
- ◆ Membership Totals by Primary Care Physician
- ◆ Bed Day Utilization Report (1 month retrospective)
- ◆ Total Claims (professional, institutional and prescription drug) Dollars Paid (1 month retrospective)
- ◆ Encounter Data (de-identified)
- ◆ Enrollment Reconciliation Report
- ◆ Disenrollment Report

**Quarterly:**

- ◆ Institutional Costs by Discharge DRG
- ◆ Inpatient Utilization by Hospital
- ◆ Prescription Drug Summary (sorted by drug)
- ◆ Out of Network Costs Report
- ◆ Disease Management Enrollment and Costs by Program and Disease Category
- ◆ ER Utilization Report

Other reports may be available at no charge and can be provided in addition to the reports listed above. Reports shall be provided in a reporting format as agreed between the parties.

## EXHIBIT F

### SUPPLEMENTAL TERMS & CONDITIONS

#### 22. DEFINITIONS

Except as expressly otherwise provided in the Agreement or unless the context otherwise requires, the following words and phrases used in this Agreement shall have the following meanings:

**“Basic Plan Benefits”** means those benefits set forth in the Evidence of Coverage.

**“Calendar Year”** means the period beginning January 1 of any year and ending December 31 of the same year.

**“Contract Year”** With the exception of the initial Contract Year, which runs from May 1, 2005 through December 31, 2005, this shall mean the period of twelve (12) months commencing on the effective date of any subsequent renewal and each twelve (12) month period thereafter, unless otherwise terminated as hereinafter provided.

**“Group”** means the City of Houston.

**“HMO”** means TEXAS HEALTHSPRING I, LLC, a Texas limited liability company organized as a health maintenance organization and licensed by the Texas Department of Insurance.

**“Member Effective Date”** means the first date on which an individual Member is entitled to receive benefits under the Plan.

**“Termination Date”** means (a) for a Member, the last date on which the Member is eligible for Coverage, or (b) for the Group, the last date on which this Agreement is in force.

#### II. TERMINATION

##### 22. Termination of Members

1. No Coverage will be provided to any Member if the Group fails to pay the Premium for the first month of this Agreement. This Agreement may be terminated for non-payment of Premium if the Group fails to pay Premiums for the second or subsequent months by the end of the thirty (30) day grace period. If so terminated, a Member's Termination Date shall be the day following the expiration of the grace period and the Member shall be liable for the cost of services received during the grace period.
2. For any Member who ceases to be eligible under the EOC or this Agreement the Termination Date shall be the date such eligibility ceases.
3. If the Member is an inpatient on the Termination Date of this Agreement, benefits will terminate for such Member at 12:01 a.m. on the day next following the Termination Date. However, in the event that Group replaces the Plan with another group health care plan or program of any kind, HMO shall cooperate with such other plan or program in the orderly transition of covered care for Members who are then inpatients.
4. For a Dependent who qualifies as a Survivor, the Termination Date shall be the earliest of the following dates:

- a. the last day of the Plan month in which such Dependent marries or remarries (but this event shall only terminate coverage of the Dependent who is marrying or remarrying, and not the coverage of the other Dependents);
- b. as to any Dependent child of the deceased Subscriber, the last day of the Plan month in which such Dependent child ceases to be a Dependent as defined by the Plan;
- c. the last day of the Plan month in which the Dependent becomes eligible for coverage hereunder as an Eligible Employee, or becomes eligible for coverage under Medicare or any other employer-sponsored policy, plan or program of group health coverage; or
- d. The date of termination of the Plan.

**B. Termination of Member Coverage**

A Member's Coverage will terminate immediately for any of the following reasons:

- 1. this Agreement terminates;
- 2. Member voluntarily disenrolls from the Plan.
- 22. the Member no longer lives in the Service Area, or if the Member resides temporarily outside the Service Area for more than six (6) consecutive months;
- 4. the Member becomes covered under an alternative Medicare Advantage Plan;
- 5. HMO's contract with CMS terminates;
- 6. Member's death.

**C. Termination of this Agreement**

- 1. The Group may terminate this Agreement for cause:
  - a. sixty (60) days after delivery of written notice by Group to HMO, upon material failure of HMO to comply with this Agreement, unless such failure described in the notice is cured within said sixty (60) days.
  - b. upon 30 days written notice to the HMO, if HMO makes a material change to any provision required by law to be disclosed to Group or Members.
- 2. HMO may terminate the Group upon ninety (90) days written notice, unless such failure described in the notice is cured within said ninety (90) days, in the case of:
  - a. The Group has committed fraud or intentional misrepresentation of a material fact to HMO; or
  - b. No Members live in the Service Area; or
  - c. Noncompliance by the Group with, or changes in, material provisions of the Plan relating to the Group's contribution toward Premium and eligibility requirements for membership in the Group, which requirements are, in accordance with State law, applicable to the offering of a group health plan in the large group market.

3. HMO may terminate the Group upon thirty (30) days' written notice in the case of non-payment of Premium through the end of the thirty (30) day grace period, and if so terminated, all Coverage will be canceled as of the day following the expiration of the grace period; provided that Members shall be financially responsible for reimbursement of the claims of Providers for Covered Services provided to Members during and subsequent to the grace period.
4. HMO may terminate the Group upon one hundred and eighty (180) days' written notice if HMO ceases to offer Coverage in the Service Area in accordance with state or federal law.
5. Except as specified above, HMO shall not have the right to terminate this Agreement.
6. The fact that Members are not notified by Group of the termination of their Coverage due to the termination of the Agreement shall not be deemed to be the continuation of a Member's Coverage beyond the date Coverage terminates.

#### **D. Notification of Members' Ineligibility**

Group shall notify HMO within thirty (30) days after a Member ceases to be eligible for benefits under this Agreement. Failure to do so will make the Group liable for any expenses incurred by the Plan, whether or not paid, due to the Group's failure to notify.

#### **E. Refunds/Credits**

If the Coverage of a Member is terminated, Premium payments received on account of the terminated Member applicable to periods after the Effective Date of termination shall be refunded or credited to Group, at HMO's sole option, within thirty (30) days, and neither HMO nor the Group shall have any further liability under this Agreement with respect to such Member. The maximum refund or credit allowable is equal to two (2) months of Premium applicable to such terminated Member, which shall include the month during which HMO is notified in writing of such termination and the next previous month, if applicable. Any claim for refund or credit by Group must be made within sixty (60) days from the Effective Date of termination of the Member's Coverage or otherwise such claims shall be deemed waived.

#### **F. Health Status Termination.**

Coverage will not be terminated on the basis of a Member's health status or health care needs, nor because a Member has exercised the Member's rights under the Appeals and Grievance process as set forth in the Evidence of Coverage.

### **III. PAYMENT REQUIREMENTS**

1. The required payments for the services and benefits made available hereunder are set forth in the Group Application and shall be due and payable in advance on or before the first day of the month for which each such payment is made or is to be made. No proration of the payments will be made under this Agreement and change in Members' status shall be effective only on the first day of each month.
2. Interest on late Premiums from the date such Premiums were due will be charged at a rate not to exceed the maximum allowable by law. Unpaid interest will be due and payable upon notice thereof to Group from HMO. However, no interest shall accrue until thirty (30) days after the Group is invoiced for the late Premium.

### **IV. IDENTIFICATION CARDS**

1. HMO shall issue identification cards for the Members.
2. Possession of an HMO identification card in and of itself confers no rights to services or other benefits. The holder of the card and the name on the card must be the same and the holder of the card

must be, in fact, a Member on whose behalf all applicable charges under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to this Agreement, through use of an HMO identification card or otherwise, shall be chargeable therefore at the actual cost of services rendered. If any Member permits the use of his or her HMO identification card by any other person, such card may be recalled and invalidated by HMO, and all rights of such Member pursuant to this Agreement may be terminated in accordance with Section II of this Agreement.

## **V. AMENDMENT OF AGREEMENT**

1. This Agreement may be amended at any time, without the consent of the Members, or any other person having beneficial interest in it, upon written request made by the Group and agreed to by HMO. Any such Amendment shall be without prejudice to any claim arising prior to the date of such Amendment.
2. HMO may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums, if necessary in order to comply with state, federal or local law. Specifically, upon mutual agreement, HMO and Group, by and through Group's Human Resources Director or such other person with similar authority, may alter or revise the terms of this Agreement and/or any Evidence of Coverage including the Summary of Benefits and Premiums as a result of changes implemented by Group or HMO as a result of the implementation of Medicare Part D. In the event of such alteration or revision, including any increase in Premium due to additional benefit enhancements, mandated benefits or expanded eligibility criteria, or other changes in laws specifically applicable to health maintenance organizations that raise HMO's cost of providing benefits under the Plan, HMO shall give the Group at least sixty (60) days prior written notice, which notice shall be considered to have been given when mailed to the Group at the address shown on the records of HMO. The alteration or revision shall become effective on the date contained in the notice, unless the Group provides written notice within fifteen (15) days after giving of notice by HMO of its intention to terminate this Agreement. Any increase in Premium must be limited to actual demonstrated cost increases and shall be approved by the Group's Human Resources Director or such other person with similar authority.
22. Furthermore, the parties acknowledge and agree that HMO may alter, amend, or otherwise modify the Member's Evidence of Coverage to increase benefits, decrease Copayments, Coinsurance, or otherwise provide Members with additional services or benefits (collectively "Enhanced Benefits") by providing Group's Human Resources Director with not less than sixty (60) days prior written notice; provided, however, that Group shall not be obligated to pay HMO additional Premiums related directly to such Enhanced Benefits.

## **VI. LIMITATIONS**

The rights of Members and obligations of HMO, participating physicians, participating Hospitals and providers under this Agreement are subject to the following limitations:

### **A. Major Disaster or Epidemic.**

In the event of any major disaster or epidemic that would severely limit the ability of participating physicians, providers and/or Hospitals to provide health care services on a timely basis, participating physicians, participating Hospitals and providers shall, in good faith, use their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available. If HMO participating physicians, participating Hospitals and providers shall have, in good faith, used their best efforts to render benefits and services in the aforesaid manner, they shall have no further liability or obligation for delay or failure to provide such benefits and services due to a shortage of available facilities or personnel resulting from such disaster or epidemic.

### **B. Circumstances Beyond HMO or Participating Physician or Provider Control.**

In the event that, due to circumstances not reasonably within the control of HMO, participating physicians or providers such as the complete or partial destruction of facilities because of war, riot, civil insurrection, or the rendering of benefits and services covered hereunder is delayed or rendered impractical, neither HMO nor any participating physician or provider shall have any liability or obligation on account of such delay or such failure to provide such benefits and services if they shall have, in good faith, used their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available.

**C. Limitations as Set Out in the Evidence of Coverage and Summary of Benefits.**

The benefits provided in the Plan are also limited by the limitations and exclusions as set out in the Evidence of Coverage.

**D. Non-Covered Services.**

HMO shall not be responsible for the reimbursement for services or treatment of complications that result from any non-covered service, procedure or treatment. HMO shall not be responsible for prescription drugs and/or medications related to any non-covered service, procedure or treatment.

**VII. MISCELLANEOUS**

**A. Records and Information**

1. HMO shall have the right, at any reasonable time, to examine the Group's records, including payroll records of employers having employees covered through the Group, with respect to eligibility and monthly payments under this Agreement.
2. Information from medical records of Members and information received from physicians or providers or facilities incident to the physician-patient provider-patient or facility-patient relationship shall be kept confidential in accordance with all applicable state and federal requirements including but not limited to HIPAA. Such information, except as reasonably necessary in connection with the administration of this Agreement, or as required by law, may not be disclosed without the written consent of the Member.
3. For the purposes of administering the Plan, HMO may, to the extent legally allowable and without further consent of or notice to any Member, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that HMO deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to HMO such information as may be necessary to implement the Plan.
4. The Application completed by Member authorizes any physician, health professional or facility to make such records, photographs or information available to HMO as HMO may reasonably request on behalf of Member.

**B. Telephone.**

The telephone number of HMO is (832) 553-3300. The facsimile number of HMO is 832-553-3419.

**C. Assignment.**

Neither party to this Agreement shall assign or transfer its rights, duties or obligations under this Agreement without the prior written consent of the other party. Other than as expressly provided by this Agreement, any attempted assignment, by operation of law or otherwise, shall be void and unenforceable. This Agreement shall inure to the benefit of and shall bind the successors and permitted assignees of the parties hereto. The benefits to a Member under this Agreement are personal to the Member and are not assignable or otherwise transferable.

**D. Severability.**

The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or enforceability of any other term or provision hereof.

**E. Incorporation by Reference.**

The Evidence of Coverage, the Application and any Amendments to any of the foregoing attached hereto, form a part of this Agreement as if fully set forth herein. Any direct conflict or ambiguity between this Agreement and the EOC will be resolved under terms most favorable to the Member.

**F. Authority.**

Any alteration or revision to this Agreement must be in writing, signed by an officer of HMO and an official of Group and attached to the affected form to be valid. No other person has the authority to change this Agreement or to waive any of its provisions.

**G. List of Providers of Services.**

From time to time, HMO will provide to the Group for dissemination to Members a list of providers who provide the services and benefits covered under this Agreement.

**H. Furnishing Information.**

Any person claiming or who may claim benefits under the Plan shall facilitate the access of or furnish to HMO such information as may be necessary to implement this Agreement, and HMO may release or obtain such information as needed to implement the provisions of this Agreement.

**I. Independent Agents.**

1. The relationships between HMO and participating facilities is that of independent contractors. Participating facilities are not agents or employees of HMO nor is HMO an employee or agent of any participating facility. Participating facilities shall maintain the facility-patient relationship with Members and shall be the only parties responsible to Members for the services that they provide.
2. The relationship between HMO and physicians and other health professionals is that of independent contractors. Physicians and health professionals are not agents or employees of HMO, nor is HMO or any employee of HMO an employee or agent of any physician or health professional. Physicians and health professionals shall maintain the physician-patient or health professional-patient relationship with Members.
3. Neither the Group nor any Member thereof is the agent or representative of HMO, and neither shall be liable for any acts or omissions of HMO, its agents or employees, any physician, any provider, or any other person or organization with which HMO has made or hereafter shall make arrangements for the performance of services under this Agreement.

**J. Provider Communication.**

HMO will not prohibit, attempt to prohibit or discourage any physician or health professional from discussing or communicating to a Member or a Member's designee any information or opinions regarding the Member's health care, any provisions of the Plan as it relates to the medical needs of the Member or the fact that the physician or health professional's contract with the HMO has terminated or that the physician or health professional will no longer be providing services under the HMO.

**K. State Law.**

If this Agreement contains any provision not in conformity with Texas state law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

**L. Incontestability.**

All statements made by a Member are considered representations and not warranties. A statement may not be used to void, cancel, or non-renew a Member's Coverage or reduce benefits unless it is in a written enrollment Application signed by the Member and a signed copy of the enrollment Application has been furnished to the Member. Coverage may only be contested because of fraud or intentional misrepresentation of material fact on

the enrollment Application.

**M. Confidentiality.**

Information contained in the medical records of Members and information received from physicians, surgeons, Hospitals or other health professionals incident to the physician-patient relationship or Hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the Member except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by HMO in connection with the administration of this Plan, or in the compiling of aggregate statistical data. Such information that is identifiable with an individual Member may not be disclosed to Group, in connection with the conduct of Appeals or otherwise, without the written consent of the affected Member.

**N. Governing Law and Venue.**

This Agreement shall be governed in all respects by the laws of the State of Texas, to the extent not otherwise superceded by Federal law, and venue for any court action shall lie in Harris County, Texas.

**O. Waiver.**

The waiver by either party of any breach of any provision of the Agreement or warranty representation herein set forth shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

**EXHIBIT II TO GROUP APPLICATION**

**Calculation of renewal rates:**

**Considered by Texas HealthSpring  
Company to be proprietary information**

**EXHIBIT III**

**TEXAS HEALTHSPRING EVIDENCE OF COVERAGE & SUMMARY OF BENEFITS**

TEXAS  
HEALTHSPRING  
MEDICARE HMO

EVIDENCE OF  
COVERAGE



# Texas HealthSpring

A MEDICARE ADVANTAGE PLAN

**EVIDENCE OF COVERAGE:  
FOR CITY OF HOUSTON RETIREES  
Your Texas HealthSpring  
Medicare HMO Plan Benefits and Services**

January 1, 2006 – December 31, 2006

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

Texas HealthSpring Customer Service  
For help or information, please call Customer Service  
Monday through Friday, 8:00 am to 5:00 pm CT.

Calls to these numbers are free:

**Local: 832-553-3480**

**Toll Free: 1-800-280-8888**

**TTY: 1-877-893-1504**

Texas HealthSpring, a Medicare Advantage Organization

## Welcome to the Texas HealthSpring Medicare HMO Plan!

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

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

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

This booklet, together with your enrollment form and any Amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of the Plan. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2006 through December 31, 2006.

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

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

### **Please tell us how we’re doing**

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

**Contents**

**Section 1 Summary of Benefits**

Summary of Benefits ..... 39

**Section 2 Introduction, General Information, Service Area, Telephone and Reference Numbers**

How to contact Texas HealthSpring Customer Service ..... 48  
How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline..... 48  
Texas State Health Insurance Assistance Program -- an organization in your state that provides free Medicare help and information..... 49  
Texas Medical Foundation/Quality Improvement Organization -- a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare ..... 49  
Other organizations (including Medicaid and the Social Security Administration) ... 49  
Railroad Retirement Board..... 50  
Employer (or "Group") Coverage ..... 50  
What is the Plan? ..... 50  
Use your Texas HealthSpring membership card instead of your red, white, and blue Medicare card ..... 51  
Help us keep your membership record up to date ..... 51  
What is the geographic Service Area for the Plan? ..... 52  
Using Plan Providers to get services covered by the Plan..... 52  
Choosing your PCP (PCP means Primary Care Physician)..... 53  
Getting care from your PCP ..... 53  
What if you need medical care when your PCP's office is closed? ..... 53  
Getting care from Specialists..... 54  
There are some services you can get on your own, without a Referral..... 54  
Getting care when you travel or are away from the Plan's Service Area..... 55  
How to change your PCP ..... 55  
What if your doctor leaves the Plan? ..... 55

***Your rights and responsibilities***

Introduction about your rights and protections ..... 56  
Your right to be treated with fairness and respect..... 56  
Your right to the privacy of your medical records and personal health information .. 56  
Your right to see Plan Providers and get Covered Services within a reasonable period of time ..... 56

Your right to know your treatment choices and participate in decisions about your health care .....	57
Your right to use advance directives (such as a living will or a power of attorney) ...	57
Your right to make complaints .....	58
Your right to get information about your health care Coverage and costs .....	58
Your right to get information about the Texas HealthSpring, the Plan, and Plan Providers .....	58
How to get more information about your rights .....	58
What can you do if you think you have been treated unfairly or your rights are not being respected?.....	59
What are your responsibilities as a Member of the Plan? .....	59

**Section 3 Definitions of some words used in this booklet**

This section either gives a definition or directs you to a place in this booklet that explains the term .....	60
---	----

**Section 4 Eligibility, Enrollment and Effective Date**

Eligibility .....	70
-------------------	----

**Section 5 Disenrollment - Leaving the Plan and your choices after you leave**

What is "Disenrollment"? .....	75
What are your choices if you leave the Plan? .....	75
How to change from the Plan to another Alternative Health Benefits Plan .....	75
Until your membership officially ends, you must keep getting your Medicare services through the Plan or you will have to pay for them yourself .....	76
What should you do if you decide to leave the Plan? .....	77
How to change from the Plan to a Medicare managed care plan or to a Fee-for-Service plan .....	78
What happens to you if the Plan leaves the Medicare program or the Plan leaves the area where you live?.....	79
You must leave the Plan if you move out of the service Area or are away from the Service Area for more than six months in a row .....	79
Under certain conditions the Plan can end your membership and make you leave the Plan.....	79

**Section 6 Premiums, Copayments and Coinsurance – what you must pay for your Medicare health Plan Coverage and for the care you receive**

Paying your share of the cost when you get Covered Services.....	81
You must pay the full cost of services that are not covered .....	81

## Section 7 Covered Services – How to obtain your Health Care Services

What is a “Medical Emergency”? .....	83
What should you do if you have a Medical Emergency? .....	83
Your PCP will help manage and follow up on your Emergency Care .....	83
What is covered if you have a Medical Emergency? .....	83
What if it wasn't really a Medical Emergency? .....	83
What is “Urgently Needed Care”? (this is different from a Medical Emergency) .....	84
Getting Urgently Needed Care when you are <u>in</u> the Plan's Service Area .....	84
Getting Urgently Needed Care when you are <u>outside</u> the Plan's Service Area .....	84

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

What are “Covered Services”? .....	85
There are some conditions that apply in order to get Covered Services .....	85
What is your Out-of-Pocket Maximum? .....	86
Benefits Chart – a list of Covered Services .....	87

#### ***Inpatient services:***

Inpatient Hospital care .....	87
Inpatient mental health care .....	88
Skilled nursing facility care .....	88
Inpatient services (when the Hospital or SNF days are not or are no longer covered) .....	88
Home health care .....	89
Hospice care .....	89
Transplants .....	90

#### ***Outpatient services:***

Physician services, including doctor office visits .....	90
Chiropractic services .....	90
Podiatry services .....	90
Outpatient mental health care .....	91
Outpatient Substance Abuse Services .....	91
Outpatient surgery .....	91
Ambulance services .....	91
Emergency Care .....	91
Urgently needed care .....	92
Outpatient Rehabilitation Services .....	92
Durable Medical Equipment and related supplies .....	92
Prosthetic devices and related supplies .....	92
Diabetes self-monitoring, training and supplies .....	93
Outpatient diagnostic tests and therapeutic services and supplies .....	93

**Preventive care and screening tests:**

Bone mass measurements.....	94
Colorectal screening .....	94
Immunizations.....	94
Mammography screening.....	95
Pap smears, and pelvic exams, clinical breast exam.....	95
Prostate cancer screening exams .....	95
Cardiovascular screening blood tests.....	95

**Other services:**

Renal Dialysis (Kidney) .....	96
Drugs that are covered under Original Medicare .....	97

**Additional benefits:**

Plan prescription drug benefit (outpatient prescription drugs).....	97
Dental services .....	99
Hearing services .....	99
Vision care .....	99
Routine physical exams .....	100
Health and wellness education.....	100
Transportation.....	100
What if you have problems getting services you believe are covered for you? .....	100
Can your benefits change during the year? .....	100
Can the prescription drugs that we cover change during the year? .....	101

**Hospital care, Skilled Nursing Facility care, and other services**

Hospital care .....	101
Skilled nursing facility care (SNF care) .....	102
Home health care.....	103
Hospice care for people who are terminally ill.....	104
Organ transplants.....	105
Participating in a clinical trial .....	105
Care in religious non-medical health care institutions .....	106

**Section 8 Prescription drugs**

Using plan pharmacies to get your outpatient prescription drugs covered by us....	107
Filling prescriptions outside the network.....	108
How do I submit a paper claim? .....	109
Specialty pharmacies .....	109
What drugs are covered by this Plan? .....	110
Drug Management Programs .....	112
How does your enrollment in this Plan affect coverage for the drugs covered	

under Medicare Part A or Part B?.....	114
Some vaccines and drugs may be administered in your doctor's office .....	114
How much do you pay for drugs covered by this Plan? .....	114
Extra help with drug plan costs for people with limited income and resources .....	118
What is the late enrollment penalty?.....	119

**Section 9 Medical care and services that are not covered (list of exclusions and limitations)**

Introduction .....	120
If you get services that are not covered, you must pay for them yourself.....	120
What services are not covered by the Plan? .....	120

**Section 10 Procedures for Reimbursement**

What should you do if you have bills from non-Plan Providers that you think we should pay? .....	123
--	-----

**Section 11 Coordination of Benefits and Subrogation**

Please keep us up-to-date on any other health insurance Coverage you have .....	126
---	-----

**Section 12 Appeals and Grievances: What to do if you have complaints**

Introduction .....	128
What are Appeals and Grievances? .....	128
This section tells how to make complaints in different situations .....	128
<i>PART 1. Making complaints (called "Appeals") to Texas HealthSpring to change a decision about what we will cover for you or what we will pay for.....</i>	129
<i>PART 2. Complaints (Appeals) to Texas HealthSpring to change a decision about what Part D drugs we will cover or pay for .....</i>	131
<i>PART 3. Making complaints if you think you are being discharged from the Hospital too soon .....</i>	133
<i>PART 4. Making complaints (appeals) if you think your Coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon .....</i>	135
<i>PART 5. Making complaints (called "Grievances") about any other type of problem you have with the Plan or one of our Plan Providers .....</i>	136
What are "complaints about your Coverage or payment for your care"? .....	138
How does the Appeals process work? .....	138
Appeals and Grievances: what to do if you have complaints about your Part D prescription drug benefit.....	147

**Section 13 Legal notices**

Notice about governing law ..... 161  
Notice about non-discrimination..... 161

**Section 14 Extra Programs and Services**

Transportation ..... 162  
Silver Sneakers Fitness Program ..... 163  
Vision ..... 164  
Hearing Discount Program ..... 164  
Dental..... 164

## SECTION 1. Summary of Benefits

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
<b>IMPORTANT INFORMATION</b>		
<p>1 - Premium and Other Important Information.</p> <p>The Out-of-Pocket Maximum does not include physician services</p>	<ul style="list-style-type: none"> <li>▪ You pay the Medicare Part B Premium of \$88.50 each month.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You continue to pay your Medicare Part B Premium of \$88.50 each month and pay any contribution required by your employer.</li>   <li>▪ There is a \$1,500 maximum Out-of-Pocket limit every year for the following Plan services:               <ul style="list-style-type: none"> <li>- Inpatient Hospital Care</li> <li>- Inpatient Mental Health Care</li> <li>- Skilled Nursing Facility</li> <li>- Home Health Care</li> <li>- Chiropractic Services</li> <li>- Podiatry Services</li> <li>- Outpatient Mental Health Care</li> <li>- Outpatient substance Abuse Care</li> <li>- Outpatient Services</li> <li>- Ambulance Services</li> <li>- Emergency Care</li> <li>- Urgently Needed Care</li> <li>- Outpatient Rehabilitation Services</li> <li>- Durable Medical Equipment</li> <li>- Prosthetic Devices</li> <li>- Diabetic Self-Monitoring Training and Supplies</li> <li>- Diagnostic Test, X-rays, and Lab Services</li> <li>- Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>- Partial Hospitalization</li> <li>- Cardiac Rehabilitation Services</li> <li>- Renal Dialysis</li> </ul> </li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
<p>3 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency #15 and Urgently Needed Care - #16.)</p>	<ul style="list-style-type: none"> <li>▪ You may go to any doctor, Specialist or Hospital that accepts Medicare.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You must go to network doctors, Specialists and Hospitals.</li> <li>▪ You need a Referral to go to network Hospitals and certain doctors, including Specialists for certain services.</li> </ul>
<b>INPATIENT CARE</b>		
<p>3 - Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<ul style="list-style-type: none"> <li>▪ You pay for each Benefit Period (3):</li> <li>▪ Days 1 - 60: an initial deductible of \$952</li> <li>▪ Days 61 - 90: \$238 each day</li> <li>▪ Days 91 - 150: \$476 each lifetime reserve day (4)</li> </ul> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>▪ \$275 per admission for Medicare-covered stay at a network Hospital.</li> <li>▪ You are covered for unlimited days each Benefit Period.</li> </ul>
<p>4 - Inpatient Mental Health Care</p>	<ul style="list-style-type: none"> <li>▪ You pay the same deductible and Copayments as inpatient Hospital care (above) except Medicare beneficiaries may only receive 190 days in a psychiatric Hospital in a lifetime.</li> </ul>	<p>You pay:</p> <ul style="list-style-type: none"> <li>▪ \$275 per admission for a Medicare-covered stay in a network Hospital.</li> <li>▪ There is a 190-day lifetime limit in a psychiatric Hospital.</li> <li>▪ The benefit days used under the Original Medicare program will count towards the 190 day lifetime reserve days when enrolling in a Medicare Advantage Plan.</li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
<p>5 - Skilled Nursing Facility (in a Medicare-certified Skilled Nursing Facility)</p>	<ul style="list-style-type: none"> <li>▪ You pay for each Benefit Period (3), following at least a 3-day covered hospital stay:</li> <li>▪ Days 1 - 20: \$0 for each day</li> <li>▪ Days 21 - 100: \$114 for each day</li> </ul> <p>There is a limit of 100 days for each Benefit Period. (3)</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>▪ \$25 each day for day(s) 1 - 100</li> <li>▪ You are covered for 100 days each Benefit Period.</li> <li>▪ No prior Hospital stay is required.</li> </ul>
<p>6 - Home Health Care (includes Medically Necessary intermittent skilled nursing care, home health aide services, and Rehabilitation Services, etc.)</p>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for all covered home health visits.</li> </ul>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for Medicare-covered home health visits.</li> </ul>
<p>7 - Hospice</p>	<ul style="list-style-type: none"> <li>▪ You pay part of the cost for outpatient drugs and inpatient respite care.</li> <li>▪ You must receive care from a Medicare-certified hospice.</li> </ul>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for Medicare-covered hospice.</li> <li>▪ You must receive care from a Medicare-certified hospice.</li> </ul>
<p>8 – Transplants</p>	<ul style="list-style-type: none"> <li>▪ You pay \$952 per confinement (up to 60 days).</li> <li>▪ You pay \$238 per day (for days 61 – 90).</li> <li>▪ You pay \$476 per each lifetime reserve day (maximum 60 lifetime reserve days).</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$952 per confinement (up to 60 days).</li> <li>▪ You pay \$238 per day (for days 61 – 90).</li> <li>▪ You pay \$476 per each lifetime reserve day (maximum 60 lifetime reserve days).</li> </ul> <p>(The transplant copayment replaces the inpatient copayment for inpatient confinements)</p>
<b>OUTPATIENT CARE</b>		
<p>9 - Doctor Office Visits</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> <li>▪ If your coverage to Medicare Part B begins on or after January 1, 2006, you may receive a one time physical exam within the first six months of your new Part B coverage.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$10 for each primary care doctor office visit for Medicare-Covered Services.</li> <li>▪ You pay \$25 for each Specialist visit for Medicare-Covered Services. (See 32 - Routine Physical Exams for more information.)</li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
	<ul style="list-style-type: none"> <li>▪ This will not include laboratory tests. Please contact your physician for further details.</li> </ul>	
10 - Chiropractic Services	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> <li>▪ You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</li> <li>▪ You pay 100% for routine care.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</li> </ul>
11 - Podiatry Services	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> <li>▪ You are covered for Medically Necessary foot care, including care for Medical Conditions affecting the lower limbs.</li> <li>▪ You pay 100% for routine care.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$25 for each Medicare-covered visit for Medically Necessary foot care.</li> </ul>
12 - Outpatient Mental Health Care	<ul style="list-style-type: none"> <li>▪ You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.</li> </ul>
13 - Outpatient Substance Abuse Care	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ For Medicare-Covered Services, you pay \$25 for each individual / group visit.</li> </ul>
14 - Outpatient Services	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</li> <li>▪ You pay 20% of outpatient facility charges. (1)(2)</li> </ul>	<p>You pay the following Copayment for Medicare-Covered Services:</p> <ul style="list-style-type: none"> <li>▪ \$200 for each Medicare-covered visit or procedure to an ambulatory surgical center.</li> <li>▪ \$200 for each Medicare-covered visit to an outpatient Hospital facility.</li> </ul>

<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Texas HealthSpring Medicare HMO Plan</b>
<p>15 - Ambulance Services (Medically Necessary ambulance services)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$100 for Medicare-covered ambulance services; you do not pay this amount if you are admitted to the Hospital.</li> </ul>
<p>16 - Emergency Care (You may go to any emergency room if you reasonably believe you need Emergency Care.)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the Hospital for the same condition within 3 days of the emergency room visit. (1)(2)</li> <li>▪ You pay 20% of doctor charges. (1)(2)</li> </ul> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<ul style="list-style-type: none"> <li>▪ You pay \$50 for each Medicare-covered emergency room visit; waived if you are admitted to the Hospital within 3 day(s).</li> <li>▪ Worldwide Coverage.</li> </ul>
<p>17 - Urgently Needed Care (This is NOT Emergency Care,)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2)</li> </ul> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<ul style="list-style-type: none"> <li>▪ You pay \$40 for each Medicare-covered Urgently Needed Care visit; waived if you are admitted to the Hospital within 3 day(s).</li> <li>▪ Worldwide Coverage.</li> </ul>
<p>18 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$25 for each Medicare-covered Occupational Therapy visit.</li> <li>▪ You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</li> </ul>
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>		
<p>19 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay 10% of the cost for each Medicare-covered item.</li> </ul>
<p>20 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay 20% of the cost for each Medicare-covered item.</li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
<p>Diabetes Self-Monitoring Training and Supplies</p> <p>(includes Coverage for glucose monitors, test strips, lancets, and self-management training)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for diabetes self-monitoring training.</li> <li>▪ 20% Copayment for diabetes supplies.</li> <li>▪ Injectable insulin – you pay \$10 (Generic) or \$30 (brand) for 30-day supply.</li> </ul>
<p>22 - Diagnostic Tests, X-Rays, and Lab Services</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2)</li> <li>▪ There is no Copayment for Medicare-approved lab services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for a Medicare-covered X-ray visit.</li> <li>▪ \$0 for each Medicare-covered clinical/diagnostic lab service.</li> <li>▪ \$25 for each Medicare-covered radiation therapy service.</li> <li>▪ \$100 CT, MRI, Cardiac Nuclear medicine.</li> <li>▪ \$150 PET scan.</li> </ul>
<p><b>PREVENTIVE SERVICES</b></p>		
<p>23 - Bone Mass Measurement</p> <p>(for people with Medicare who are at risk)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for each Medicare-covered Bone Mass Measurement.</li> </ul>
<p>24 - Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for Members 50 years of age or older as follows:</li> <li>▪ \$0 Copayment for sigmoidoscopy every four years</li> <li>▪ \$0 Copayment for colonoscopy every ten years (not at high risk)</li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
<p>25 - Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for the pneumonia and flu vaccines.</li> <li>▪ You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)</li> <li>▪ You may only need the pneumonia vaccine once in your lifetime.</li> </ul> <p>Please contact your doctor for further details.</p>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for the Pneumonia and Flu vaccines. (No Referral necessary).</li> <li>▪ \$0 Copayment for the Hepatitis B vaccine.</li> </ul>
<p>26 – Mammograms</p> <p>(Annual Screening) (for women with Medicare age 40 and older)</p>	<ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts. (2)</li> </ul> <p>No Referral necessary for Medicare-covered screenings.</p>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for Medicare-covered screening mammograms. (No Referral necessary).</li> </ul>
<p>27 - Pap Smears and Pelvic Exams</p> <p>(for women with Medicare)</p>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for a pap smear once every 2 years, annually for beneficiaries at high risk. (2)</li> <li>▪ You pay 20% of Medicare-approved amounts for pelvic exams. (2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for Medicare-covered Pap Smears or Pelvic Exams.</li> </ul>
<p>28 - Prostate Cancer Screening Exams</p> <p>(for men with Medicare age 50 and older)</p>	<ul style="list-style-type: none"> <li>▪ There is no Copayment for approved lab services and a Copayment of 20% of Medicare-approved amounts for other related services. (2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$0 Copayment for Medicare-covered Prostate Cancer screening exams.</li> </ul>
<p><b>ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)</b></p>		
<p>29 - Outpatient Prescription Drugs</p>	<ul style="list-style-type: none"> <li>▪ If you choose not to enroll in Medicare Part D, you pay 100% for most prescription drugs.</li> <li>▪ If you enroll in a Prescription Drug Plan your prescriptions will be covered in accordance with the benefits of that plan and as required by Medicare.</li> </ul>	<ul style="list-style-type: none"> <li>• Formulary Generic Drugs <ul style="list-style-type: none"> <li>- \$10 (30-day) supply</li> <li>- \$30 (90-day) supply</li> </ul> </li> <li>• Formulary Preferred Brand Drugs <ul style="list-style-type: none"> <li>- \$30 (30-day) supply</li> <li>- \$90 (90-day) supply</li> </ul> </li> <li>• Specialty Brand Drugs <ul style="list-style-type: none"> <li>- \$45 (30-day) supply</li> <li>- \$135 (90-day) supply</li> </ul> </li> <li>• After \$3600 annual out-of-</li> </ul>

<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Texas HealthSpring Medicare HMO Plan</b>
		<p>pocket is met, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- Generic or Preferred Brand Multi-Source Drugs \$2 (30-day supply) or 5% coinsurance <ul style="list-style-type: none"> <li>• Specialty Drugs</li> </ul> </li> <li>- \$5 (30-day) supply or 5% coinsurance <ul style="list-style-type: none"> <li>• Certain classifications of drugs have quantity limits and/or are subject to prior authorization. Authorization may be required for prescription drugs</li> <li>• Formulary may change on a monthly basis, except in the event a medication poses a safety risk to the member either in the discretion of Texas HealthSpring or the FDA.</li> <li>• There is no annual limit for retail and mail-order preferred brand name prescriptions</li> </ul> </li> </ul>
30 - Dental Services	<ul style="list-style-type: none"> <li>▪ In general, you pay 100% for dental services.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Value added discount program that provides a discount up to 50% for certain dental services at selected providers.</li> </ul>
31 - Hearing Services	<ul style="list-style-type: none"> <li>▪ You pay 100% for routine hearing exams and hearing aids.</li> <li>▪ You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$25 for each Medicare-covered hearing exam (diagnostic hearing exams).</li> <li>▪ Value added discount program that provides a discount up to 30% for hearing tests and hearing aid at selected providers.</li> </ul>
32 - Vision Services	<ul style="list-style-type: none"> <li>▪ You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</li> <li>▪ For people with Medicare who</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$0 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery).</li> <li>▪ You pay \$25 for each Medicare-</li> </ul>

Benefit Category	Original Medicare	Texas HealthSpring Medicare HMO Plan
	<p>are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <ul style="list-style-type: none"> <li>▪ You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</li> <li>▪ You pay 100% for routine eye exams and glasses.</li> </ul>	<p>covered eye exam (diagnosis and treatment for diseases and conditions of the eye only).</p>
33 - Routine Physical Exams	<ul style="list-style-type: none"> <li>▪ You pay 100% for routine physical exams.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$10 for each routine physical exam, up to 1 exam every year.</li> </ul>
34 - Transportation	<ul style="list-style-type: none"> <li>▪ You pay 100%.</li> </ul>	<ul style="list-style-type: none"> <li>▪ You pay \$0 for each one-way trip up to 15 round trips to Plan approved locations every year.</li> </ul>
35 – Silver Sneakers ®Fitness Program		<ul style="list-style-type: none"> <li>▪ You pay \$0 copay.</li> </ul>

(1) Each year, you pay a total of one \$124 deductible.

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

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

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