



# 2010 Summary of Benefits

## Dual Advantage Plan (Regional PPO)



**CARE IMPROVEMENT PLUS**

*Medicare/Medicaid Special Needs Plan*





## **Introduction to the Summary of Benefits**

### **CARE IMPROVEMENT PLUS DUAL ADVANTAGE (REGIONAL PPO)**

**January 1, 2010 -  
December 31, 2010**

#### **TEXAS**

#### **Care Improvement Plus**

##### **Current Members:**

**1-800-204-1002**

**TTY: 1-800-713-1603**

##### **Prospective Members:**

**1-800-711-1656**

**TTY: 1-800-713-1603**

**7 days-a-week**

**8:00 am – 8:00 pm**

## **Section I – Introduction To The Summary Of Benefits**

Thank you for your interest in Care Improvement Plus Dual Advantage (Regional PPO). Our plan is offered by CARE IMPROVEMENT PLUS OF TEXAS INSURANCE COMPANY/Care Improvement Plus, a Medicare Advantage Preferred Provider Organization (PPO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call Care Improvement Plus Dual Advantage (Regional PPO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Care Improvement Plus Dual Advantage (Regional PPO) and ask for the "Evidence of Coverage."

### **YOU HAVE CHOICES IN YOUR HEALTH CARE**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Care Improvement Plus Dual Advantage (Regional PPO). You may have other options too.

You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Care Improvement Plus Dual Advantage (Regional PPO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### **HOW CAN I COMPARE MY OPTIONS?**

You can compare Care Improvement Plus Dual Advantage (Regional PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### **WHERE IS Care Improvement Plus Dual Advantage (Regional PPO) AVAILABLE?**

The service area for this plan includes: Texas. You must live in this area to join the plan.

## **WHO IS ELIGIBLE TO JOIN Care Improvement Plus Dual Advantage (Regional PPO)?**

You can join Care Improvement Plus Dual Advantage (Regional PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease generally are not eligible to enroll in Care Improvement Plus Dual Advantage (Regional PPO) unless they are members of our organization and have been since their dialysis began.

You must also be enrolled in the Texas Medicaid program to join this plan. Please call plan to see if you are eligible to join.

*See page 24 for information about Who Is Eligible To Join?*

## **CAN I CHOOSE MY DOCTORS?**

Care Improvement Plus Dual Advantage (Regional PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at [www.careimprovementplus.com](http://www.careimprovementplus.com). Our customer service number is listed at the end of this introduction.

*See page 24 for information about Can I Choose My Doctors?*

## **WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

## **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

Care Improvement Plus Dual Advantage (Regional PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## **WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

Care Improvement Plus Dual Advantage (Regional PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.careimprovementplus.com](http://www.careimprovementplus.com). Our customer service number is listed at the end of this introduction.

## **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Care Improvement Plus Dual Advantage (Regional PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.careimprovementplus.com](http://www.careimprovementplus.com).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?**

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

## **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Care Improvement Plus Dual Advantage (Regional PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Texas Health Information Counseling and Advocacy Program (HICAP) (800) 252-9240.

As a member of Care Improvement Plus Dual Advantage (Regional PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Texas Health Information Counseling and Advocacy Program (HICAP) (800) 252-9240.

*See page 24 for information about What Are My Protections In This Plan?*

## **WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Care Improvement Plus Dual Advantage (Regional PPO) for more details.

## **WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Care Improvement Plus Dual Advantage (Regional PPO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

## **PLAN RATINGS**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-204-1002 (TTY: 1-800-713-1603) 7 days-a-week, 8:00 am – 8:00 pm, to obtain a copy of the plan ratings for this plan.

**Please call Care Improvement Plus for more information about Care Improvement Plus Dual Advantage (Regional PPO).**

**Visit us at [www.careimprovementplus.com](http://www.careimprovementplus.com) or, call us:**

**Customer Service Hours:** 7 days-a-week, 8:00 a.m. - 8:00 p.m.

Current members should call toll-free  
(800) 204-1002 for questions related  
to the Medicare Advantage Program.  
TTY (800) 713-1603

Prospective members should call toll-free  
(800) 711-1656 for questions related  
to the Medicare Advantage Program.  
TTY (800) 713-1603

Current members should call toll-free  
(866) 673-3561 for questions related to the  
Medicare Part D Prescription Drug program.  
TTY (866) 673-3563

Prospective members should call toll-free  
(800) 711-1656 for questions related to the  
Medicare Part D Prescription Drug program.  
TTY (800) 713-1603

For more information about Medicare,  
please call Medicare at 1-800-MEDICARE  
(1-800-633-4227).

TTY users should call 1-877-486-2048.  
You can call 24 hours a day, 7 days-a-week.

Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats. Contact the plan for more details at 1-800-204-1002  
(TTY: 1-800-713-1603) 7 days-a-week, 8:00 am – 8:00 pm.

If you have any questions about this plan's benefits or costs, please contact Care Improvement Plus for details.

## Section II – Summary of Benefits

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>IMPORTANT INFORMATION</b>		
<p><b>1. Premium and Other Important Information</b></p>	<p>In 2010 the monthly Part B Premium is \$0 and the yearly Part B deductible amount is \$0.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p><b>General</b> \$0 monthly plan premium in addition to your monthly Medicare Part B premium</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p><b>In-Network</b> \$90,000 out-of-pocket limit. This limit includes only Medicare-covered services.</p> <p><b>Out-of-Network</b> \$90,000 out-of-pocket limit. This limit includes only Medicare-covered services.</p> <p><b>In and Out-of-Network</b> \$90,000 out-of-pocket limit.</p> <p>In-Network: This limit includes only Medicare-covered services.</p> <p>Out-Of-Network: This limit includes only Medicare-covered services.</p> <p><i>See page 22 for information about Premium and Other Important Information.</i></p>
<p><b>2. Doctor and Hospital Choice</b> (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists, and hospitals.</p>

**Benefit****Original Medicare****Care Improvement Plus  
Dual Advantage (Regional PPO)**

## INPATIENT CARE

**3. Inpatient Hospital Care**  
(includes  
Substance Abuse and  
Rehabilitation Services)

For each benefit period:  
 Days 1 - 60: \$0 deductible\*  
 Days 61 - 90: \$0 per day\*  
 Days 91 - 150: \$0 per lifetime reserve day\*

Call 1-800-MEDICARE (1-800-633-4227)  
for information about lifetime reserve days.

Lifetime reserve days can only be used  
once.

A "benefit period" starts the day you go into  
a hospital or skilled nursing facility. It ends  
when you go for 60 days in a row without  
hospital or skilled nursing care. If you go  
into the hospital after one benefit period  
has ended, a new benefit period begins.  
There is no limit to the number of benefit  
periods you can have.

**In-Network**

You will not be charged additional cost sharing for  
professional services.

\$0 yearly deductible\*

\$0 copay\*

Plan covers 90 days each benefit period.

Except in an emergency, your doctor must tell the plan that  
you are going to be admitted to the hospital.

**Out-of-Network**

In 2010 the amounts for each benefit period are:

Days 1 - 60: \$0 deductible

Days 61 - 90: \$0 per day

Days 91 - 150: \$0 per lifetime reserve day

*See page 22 for information about Inpatient Hospital Care.*

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<p><b>4. Inpatient Mental Health Care</b></p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b> Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")</p> <p>\$0 yearly deductible*</p> <p>\$0 copay*</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b> Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")</p> <p><i>See page 22 for information about Inpatient Mental Health Care.</i></p>
<p><b>5. Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 per day* Days 21 - 100: \$0 per day*</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 yearly deductible* \$0 copay for SNF services*</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>For non-Medicare-covered SNF stays: Days 1 - 20: \$0 per day Days 21 - 100: \$0 per day</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p><b>Out-of-Network</b> In 2010 the amounts for each benefit period are: Days 1 - 20: \$0 per day Days 21 - 100: \$0 per day</p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>6. Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered home health visits.*  <b>Out-of-Network</b> \$0 copay for home health visits.
<b>7. Hospice</b>	You pay part of the cost for outpatient drugs.  You must get care from a Medicare-certified hospice.	<b>General</b> You must get care from a Medicare-certified hospice.
<b>OUTPATIENT CARE</b>		
<b>8. Doctor Office Visits</b>	0% coinsurance	<b>General</b> See "Physical Exams," for more information.  <b>In-Network</b> \$0 copay for each primary care doctor visit for Medicare-covered benefits.*  \$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.*  \$0 copay for each specialist doctor visit for Medicare-covered benefits.*  <b>Out-of-Network</b> \$0 copay for each primary care doctor visit.  \$0 copay for each specialist visit.

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>9. Chiropractic Services</b>	<p>Routine care not covered.</p> <p>0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered chiropractic visits.*</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>Out-of-Network</b> \$0 copay for chiropractic benefits.</p>
<b>10. Podiatry Services</b>	<p>Routine care not covered.</p> <p>0% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered podiatry benefits.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> \$0 copay for podiatry benefits.</p>
<b>11. Outpatient Mental Health Care</b>	<p>0% coinsurance for most outpatient mental health services.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered Mental Health visits.* \$0 copay for each Medicare-covered visit with a psychiatrist.*</p> <p><b>Out-of-Network</b> \$0 copay for Mental Health benefits. \$0 copay for Mental Health benefits with a psychiatrist.</p>
<b>12. Outpatient Substance Abuse Care</b>	<p>0% coinsurance</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered visits.*</p> <p><b>Out-of-Network</b> \$0 copay for outpatient substance abuse benefits.</p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>13. Outpatient Services/Surgery</b>	0% coinsurance for the doctor 0% of outpatient facility charge	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit.*  \$0 copay for each Medicare-covered outpatient hospital facility visit.*</p> <p><b>Out-of-Network</b> \$0 copay for ambulatory surgical center benefits.  \$0 copay for outpatient hospital facility benefits.</p>
<b>14. Ambulance Services</b> (medically necessary ambulance services)	0% coinsurance	<p><b>In-Network</b> \$0 copay for Medicare-covered ambulance benefits.*</p> <p><b>Out-of-Network</b> \$0 copay for ambulance benefits.</p>
<b>15. Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	0% coinsurance for the doctor 0% of facility charge or 0% per emergency room visit  You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.  NOT covered outside the U.S. except under limited circumstances.	<p><b>General</b> \$0 copay for Medicare-covered emergency room visits.*  Worldwide coverage.</p> <p><i>See page 22 for information about Emergency Care.</i></p>
<b>16. Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	0% coinsurance  NOT covered outside the U.S. except under limited circumstances.	<p><b>General</b> \$0 copay for Medicare-covered urgent-care visits.*</p> <p><i>See page 22 for information about Urgently Needed Care.</i></p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>17. Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	0% coinsurance	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered Occupational Therapy visits.*  \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.*  <b>Out-of-Network</b> \$0 copay for Occupational Therapy benefits.  \$0 copay for Physical and/or Speech/Language Therapy visits.
<hr/> OUTPATIENT MEDICAL SERVICES AND SUPPLIES <hr/>		
<b>18. Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	0% coinsurance	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered items.*  <b>Out-of-Network</b> \$0 copay for durable medical equipment.
<b>19. Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	0% coinsurance	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$0 copay for Medicare-covered items.*  <b>Out-of-Network</b> \$0 copay for prosthetic devices.

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<p><b>20. Diabetes</b>  <b>Self-Monitoring Training, Nutrition Therapy, and Supplies</b>  (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b>  \$0 copay for Diabetes self-monitoring training.*  \$0 copay for Nutrition Therapy for Diabetes.*  \$0 copay for Diabetes supplies.*</p> <p><b>Out-of-Network</b>  \$0 copay for Diabetes self-monitoring training.  \$0 copay for Nutrition Therapy for Diabetes.  \$0 copay for Diabetes supplies.</p>
<p><b>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></p>	<p>0% coinsurance for diagnostic tests and X-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b>  Authorization rules may apply.</p> <p><b>In-Network</b>  \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> <li>- lab services*</li> <li>- diagnostic procedures and tests*</li> <li>- X-rays.*</li> <li>- diagnostic radiology services (not including X-rays)*</li> <li>- therapeutic radiology services*</li> </ul> <p><b>Out-of-Network</b>  \$0 copay for diagnostic procedures, tests, and lab services.  \$0 copay for therapeutic radiology services  \$0 copay for outpatient x-rays.  \$0 copay for diagnostic radiology services</p> <p><i>See page 22 for information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.</i></p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>PREVENTIVE SERVICES</b>		
<b>22. Bone Mass Measurement</b> (for people with Medicare who are at risk)	0% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement* <b>Out-of-Network</b> \$0 copay for Medicare-covered bone mass measurement.
<b>23. Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	0% coinsurance Covered when you are high risk or when you are age 50 and older.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.* <b>Out-of-Network</b> \$0 copay for colorectal screenings.
<b>24. Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 0% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine.* No referral needed for Flu and Pneumonia vaccines. <b>Out-of-Network</b> \$0 copay for immunizations. \$0 copay for immunizations.
<b>25. Mammograms</b> (Annual Screening) (for women with Medicare age 40 and older)	0% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.* <b>Out-of-Network</b> \$0 copay for screening mammograms.

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<p><b>26. Pap Smears and Pelvic Exams</b> (for women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>0% coinsurance for Pelvic Exams</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.*</p> <p><b>Out-of-Network</b> \$0 copay for pap smears and pelvic exams. \$0 copay for pap smears and pelvic exams.</p>
<p><b>27. Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p>	<p>0% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 0% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening*</p> <p><b>Out-of-Network</b> \$0 copay for prostate cancer screening.</p>
<p><b>28. End-Stage Renal Disease</b></p>	<p>0% coinsurance for renal dialysis</p> <p>0% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b> \$0 copay for renal dialysis* \$0 copay for Nutrition Therapy for End-Stage Renal Disease*</p> <p><b>Out-of-Network</b> \$0 copay or renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>29. Prescription Drugs</b>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>\$0 yearly deductible for Part B-covered drugs.*</p> <p>\$0 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>\$0 copay for Part B drugs out-of-network.</p> <p><i>See page 22 for information about Prescription Drugs.</i></p> <p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.careimprovementplus.com">www.careimprovementplus.com</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>- have limited incomes,</li> <li>- live in long term care facilities, or</li> <li>- have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Care Improvement Plus Dual Advantage (Regional PPO) for certain drugs.</p>

**Benefit****Original Medicare****Care Improvement Plus  
Dual Advantage (Regional PPO)****29. Prescription Drugs**  
(continued)

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Care Improvement Plus Dual Advantage (Regional PPO) approves the exception, you will pay Formulary Non-Preferred Brand cost-sharing for that drug.

**In-Network**

You pay a \$0 yearly deductible.

**Initial Coverage**

Depending on your income and institutional status, you pay the following:

For generic drugs (including brand drugs treated as generic), either:

- A \$0 copay or
- A \$1.10 copay or
- A \$2.50 copay

For all other drugs, either:

- A \$0 copay or
- A \$3.30 copay or
- A \$6.30 copay.

Benefit	Original Medicare	Care Improvement Plus Dual Advantage (Regional PPO)
---------	-------------------	---

**29. Prescription Drugs**  
(continued)

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 copay.

**Out-of-Network**

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Care Improvement Plus Dual Advantage (Regional PPO).

**Out-of-Network Initial Coverage**

Depending on your income and institutional status, you will be reimbursed by Care Improvement Plus Dual Advantage (Regional PPO) up to the full cost of the drug minus the following:

For generic drugs purchased out-of-network (including brand drugs treated as generic), either:

- A \$0 copay or
- A \$1.10 copay or
- A \$2.50 copay

For all other drugs purchased out-of-network, either:

- A \$0 copay or
- A \$3.30 copay or
- A \$6.30 copay.

**Out-of-Network Catastrophic Coverage**

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>30. Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b>            \$0 copay for Medicare-covered dental benefits.*            \$15 copay for an office visit that includes:            - up to 1 oral exam(s) every year            - up to 1 cleaning(s) every year            - up to 1 dental X-ray(s) every year</p> <p><b>Out-of-Network</b>            \$0 copay for comprehensive dental benefits.            \$15 copay for preventive dental benefits.            \$0 copay for comprehensive dental benefits.</p> <p><b>In and Out-of-Network</b>            Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.  <i>See page 23 for information about Dental Services.</i></p>
<b>31. Hearing Services</b>	Routine hearing exams and hearing aids not covered.  0% coinsurance for diagnostic hearing exams.	<p><b>In-Network</b>            In general, routine hearing exams and hearing aids not covered.            \$0 copay for Medicare-covered diagnostic hearing exams*</p> <p><b>Out-of-Network</b>            \$0 copay for hearing exams.</p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>32. Vision Services</b>	<p>0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>In-Network</b></p> <p>\$0 copay for diagnosis and treatment for diseases and conditions of the eye*</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery *</p> <p>-\$10 copay for up to 1 routine eye exam(s) every year</p> <p>-\$0 copay for glasses</p> <p>-\$0 copay for contacts.</p> <p>\$200 limit for eye wear every year.</p> <p><b>Out-of-Network</b></p> <p>\$0 copay for eye wear.</p> <p>\$10 copay for eye exams.</p> <p>\$0 copay for eye exams.</p> <p>\$0 copay or eye wear.</p> <p><i>See page 23 for information about Vision Services.</i></p>
<b>33. Physical Exams</b>	<p>0% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b></p> <p>\$0 copay for routine exams.</p> <p>\$0 copay for Medicare-covered benefits.*</p> <p>Limited to 1 exam every year.</p> <p>\$0 copay for Medicare-covered benefits*</p> <p><b>Out-of-Network</b></p> <p>\$0 copay for routine exams.</p>

<b>Benefit</b>	<b>Original Medicare</b>	<b>Care Improvement Plus Dual Advantage (Regional PPO)</b>
<b>Health/Wellness Education</b>	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>-Written health education materials, including Newsletters</li> <li>-Nutritional Training</li> <li>-Additional Smoking Cessation</li> <li>-Written health education materials, including Newsletters</li> <li>-Nutritional Training</li> <li>-Additional Smoking Cessation</li> <li>-Nursing Hotline</li> <li>-Other Wellness Benefits</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.*</p> <p><b>Out-of-Network</b> \$0 copay for Health and Wellness services.</p> <p><i>See page 23 for information about Health/Wellness Education.</i></p>
<b>Transportation</b> (Routine)	Not covered.	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for up to 22 one-way trips to plan-approved location every year.</p> <p><b>Out-of-Network</b> \$0 copay for transportation.</p> <p><i>See page 23 for information about Transportation.</i></p>
<b>Acupuncture</b>	Not covered.	<p><b>In-Network</b> This plan does not cover Acupuncture.</p>

## **Section III – Additional Benefit Information**

### **Clarification to Benefits in Section II**

#### **1 Premium and Other Important Information**

In- and Out-of-Network

\$90,000 out-of-pocket limit. This limit includes only Medicare-covered items.

#### **3 Inpatient Hospital Care**

Care Improvement Plus requires authorization for inpatient hospital care.

#### **4 Inpatient Mental Health Care**

Care Improvement Plus requires prior authorization for inpatient mental health care.

#### **15 Emergency Care**

Care Improvement Plus provides coverage for Medicare-covered emergency care observation benefit. If you are immediately admitted to the hospital, you pay \$0 for the emergency care observation benefit.

With the Dual Advantage Plan, you'll pay \$0 for Medicare-covered emergency care observation benefit.

#### **16 Urgently Needed Care**

General

You'll have a \$0 copay for Medicare-covered urgent-care visits. This benefit is NOT covered outside the U.S except under limited circumstances.

#### **21 Diagnostic Tests, X-rays, Lab Services and Radiology Services**

Copays in this section do not apply to services received during your doctor's office visit at the doctor's office. If you go to a free-standing facility for these services you are responsible for this copay. Copays in this section do not apply to services administered during an Inpatient Hospital, Skilled Nursing Facility, or Inpatient Mental Health Facility stay. Please reference these sections in this Summary of Benefits for additional information on your cost sharing associated with these services.

#### **29 Prescription Drugs**

Your provider must get prior authorization from Care Improvement Plus for certain Medicare Part B drugs administered at the doctor's office.

### **30 Dental Services**

In- and Out-of Network

Your dental coverage includes dentures, periodic exams, cleanings and X-rays.

You will pay \$15 copay for routine preventive office visits.

(If you are a full dual beneficiary, you will have a \$0 copay for routine preventive dental office visit.) Your routine preventive office visit includes:

- 1 periodic or 1 comprehensive oral exam (either 1 periodic exam every year or 1 comprehensive exam once every 3 years)
- 1 cleaning every year
- 1 set of bitewing X-rays every year (2 or 4 films)
- Up to 5 intraoral X-rays every year (initial film and up to 4 additional films)
- Denture adjustments (2 of any 4 denture adjustments per year)

Additionally you are covered for these services:

- Periodontal scaling (2 quadrants of scaling per year)
- Restorative services (4 restorations per year, not to exceed 6 surfaces per year)
- Dentures (2 dental plates, either full or partial, or any combination thereof, once every 3 years)

### **32 Vision Services**

In- and Out-of-Network

Your vision coverage includes:

\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery

\$0 copay for exams to diagnose and treat diseases and conditions of the eye

\$10 copay for up to 1 routine eye exam every year (If you are a full dual beneficiary, you will have a \$0 copay for routine eye exam visit.)

\$200 limit for eye wear every year

### **33 Transportation**

In- and Out-of-Network

You will have a \$0 copay for up to 22 one-way trip(s) to plan-approved locations every year. Plan members are encouraged to use network transportation providers. You may go to non-network providers, pay a fee for transportation services, and submit your receipt for reimbursement. Contact the plan for details. To schedule a pick-up, call 1-888-240-6435.

### **33. Health/Wellness Education**

As a member of Care Improvement Plus, you'll receive health-related information and education on topics such as diabetes and heart failure.

# Additional Benefit Information

## Introduction

### Who is eligible to join the Dual Advantage (Regional PPO) Plan?

Care Improvement Plus Dual Advantage (Regional PPO) is a Medicare Advantage plan available to individuals who meet the following criteria: Medicare beneficiaries living in Texas who are entitled to Medicare Part A, enrolled in Part B, and enrolled in state Medicaid (specifically QMB, QMB+ and SLMB+), and dual eligible beneficiaries whom the state holds harmless for Part A and Part B cost sharing. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Care Improvement Plus unless they are members of our organization and have been since their dialysis began.

### Can I choose my doctors?

Care Improvement Plus Dual Advantage (Regional PPO) offers an open access provider network — you may go to any Medicare-approved provider who will accept payment from our plan and from Medicaid. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list of contracted providers or visit us at [www.careimprovementplus.com](http://www.careimprovementplus.com). You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call Member Services at 1-800-204-1002 (TTY: 1-800-713-1603) 7 days-a-week 8am-8pm.

### What are my protections in this plan?

Your health and satisfaction are important to us. When you have a problem or concern, please call Member Services 1-800-204-1002 (TTY 1-800-713-1603) 7 days-a-week 8am – 8pm. We will work with you to try to find a satisfactory solution to your problem. You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

## Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

There are two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

## Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

- When a coverage decision involves your medical care, the initial determination is called an **“organization determination.”**
  - **“Standard” Organization determinations** are reviewed for medical necessity with a determination as to whether to provide or reimburse the care or service within 14 days of the request.
  - **“Expedited” Organization Determinations** may be requested where adherence to a standard organization determination would seriously jeopardize the life or health of the plan member or the ability of the member to regain maximum function. An expedited organization determination must be processed and decision rendered within 3 calendar days.

**For an organization determination, call or have your provider contact the Utilization Management Department at 1-888-625-2204 and follow the prompts. Or Write to Care Improvement Plus, attn: Utilization Management Department, 351 W. Camden Street, Suite 100 Baltimore, MD 21201.**

- When the coverage decision is about your Part D drugs, the initial determination is called a **“coverage determination.”** Here are examples of coverage decisions you ask us to make about your Part D drugs:
  - You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs* but we require you to get approval from us before we will cover it for you.)
  - You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.
  - You ask us to make a formulary exception, including:
    - Asking us to cover a Part D drug that is not on the plan’s Formulary
    - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
    - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

**For a coverage determination, please call Pharmacy Services at 1-800-753-2851 (TTY: 1-800-713-1603) or write to Medco Health Solutions attn: Medicare Reviews PO Box 63067 Irvin, TX 75063-0118. Formulary exception requests can be made by calling Member Services at 1-800-204-1002 (TTY 1-800-713-1603) 7 days-a-week 8am – 8pm.**

If you disagree with a coverage decision we have made, you can appeal our decision.

**To obtain a standard pharmacy appeal, send appeal request in writing to Care Improvement Plus:**

**By mail: Care Improvement Plus  
351 W. Camden Street, Suite 100  
Baltimore, MD 21201  
Attn: Pharmacy Department**

**By fax for pharmacy appeals: 1-866-272-2942**

**To obtain an expedited appeal:**

**By phone: 1-800-204-1002 (TTY: 1-800-713-1603)**

**By fax: 1-866-272-2942**

## **Making an Appeal**

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. All requests for an appeal must be made in writing. When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review, we give you our decision.

### **To obtain a standard appeal, send appeal request in writing to Care Improvement Plus:**

**By mail:** Care Improvement Plus  
351 W. Camden Street, Suite 100  
Baltimore, MD 21201  
Attn: Compliance Appeals Department

**By fax for appeals:** 1-866-272-2942

### **To obtain an expedited appeal:**

**By phone:** 1-800-213-0672 (TTY: 1-800-713-1603)

**By fax:** 1-866-272-2942

## **Making Complaints**

If you are dissatisfied or have a complaint about any aspect of Care Improvement Plus, you may call or write our Member Services department. Complaints other than those involving organization determinations or coverage determinations are called grievances. (Complaints about denials and other adverse organization determinations or coverage determinations are handled as appeals, and are not grievances.) We will investigate the grievance and respond to you in a timely manner. Complaints about denied requests for an expedited decision or appeal, or disagreements over time extensions, will be handled as expedited grievances – they are reviewed and resolved within 24 hours.

### **To make a grievance, send your request in writing to Care Improvement Plus:**

**By mail:** Care Improvement Plus  
351 W. Camden Street, Suite 100  
Baltimore, MD 21201  
Attn: Compliance Department

**By fax:** 1-866-272-2908

### **To obtain an expedited grievance:**

**By phone:** 1-800-204-1002 (TTY: 1-800-713-1603)

**By fax:** 1-866-272-2908

## Section IV

### Overview and Eligibility

Care Improvement Plus Dual Advantage is a Medicare Advantage Dual Special Needs Plan.

To be eligible to join Care Improvement Plus Dual Advantage you must:

- 1) be entitled to Medicare Part A and enrolled in Medicare Part B
- 2) be enrolled in the Texas State Medicaid program (specifically QMB, QMB+, and SLMB+, whereby your A/B cost sharing is covered by State Medicaid)
- 3) live in the plan's service area

The service area for the Care Improvement Plus Dual Advantage plan is: the entire state of Texas.

For those enrolled in the Texas State Medicaid program:

Benefits are provided to beneficiaries according to the Texas Medicaid State Plan. The current list of Medicaid benefits (mandatory and optional services) is included in the chart below:

### Texas Medicaid Summary of Benefits

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Monthly Premium</b>	Medicaid assistance with premium payment may vary based on your level of Medicaid eligibility.
<b>Doctor and Hospital Choice</b>	For those who meet QMB requirements, Medicaid pays coinsurance, co-payments and deductibles for Medicare covered services. Members should follow Medicare guidelines related to hospital and doctor choice. \$0 copay for Medicaid-covered services.
<b>Inpatient Hospital Care</b> (Includes Substance Abuse and Rehabilitation Services)	Admissions for the single diagnosis of chemical dependency or abuse without an accompanying medical complication are not a benefit of Texas Medicaid. For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Inpatient Mental Health Care</b>	Inpatient admissions to acute care hospitals for psychiatric conditions are a benefit of Texas Medicaid. For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Skilled Nursing Facility (SNF)</b> (In a Medicare-certified Skilled Nursing Facility)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Home Health Care</b> (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Hospice</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Doctor Office Visits</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Chiropractic Services</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Podiatry Services</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Outpatient Mental Health Care</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Outpatient Substance Abuse Care</b>	For Dual-eligible Members under age 21, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Outpatient Services/Surgery</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Ambulance Services</b> (medically necessary ambulance services)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	For Dual-eligible Members under age 21 (CCP), Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Bone Mass Measurement</b> (for people with Medicare who are at risk)	This is not a benefit.
<b>Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Mammograms</b> (Annual Screening) (for women with Medicare age 40 and older)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Pap Smears and Pelvic Exams</b> (for women with Medicare)	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.
<b>Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)	For Dual-eligible Members, Medicaid managed care pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. This will be a FFS benefit in December 2009. \$0 copay for Medicaid-covered services.
<b>End-Stage Renal Disease</b>	For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. \$0 copay for Medicaid-covered services.

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Prescription Drugs</b>	\$0 copayment for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.
<b>Dental Services</b>	<p>This is a benefit only for THSteps eligible clients and for clients in an ICF-MR who are over 21 years of age and older.</p> <p>For Dual-eligible Members who meet the above criteria, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 copay for Medicaid-covered services.</p>
<b>Hearing Services</b>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 copay for Medicaid-covered services.</p>
<b>Vision Services</b>	<p>For Dual-eligible Members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 copay for Medicaid-covered services.</p>
<b>Physical Exams</b>	<p>For Dual-eligible Members, Medicaid managed care pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. This will be a FFS benefit in December 2009.</p> <p>\$0 copay for Medicaid-covered services.</p>
<b>Health/Wellness Education</b> <ul style="list-style-type: none"> <li>• Written health education materials, including Newsletters</li> <li>• Nutritional Training</li> <li>• Additional Smoking Cessation</li> <li>• Other Wellness Benefits</li> </ul>	<p>This is not a Texas Medicaid benefit but is available in some of the pilot programs like the Diabetes and Asthma projects.</p> <p>For Dual-eligible Members participating in the Diabetes and Asthma pilot programs, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 copay for Medicaid-covered services.</p>
<b>Transportation</b> (Routine)	<p>For Dual-eligible Members, Medicaid Medical Transportation provides this service if it is not covered by Medicare or when the Medicare benefit is exhausted.</p> <p>\$0 copay for Medicaid-covered services.</p>

<b>Benefit Category</b>	<b>Texas Medicaid</b>
<b>Acupuncture</b>	This is not a benefit.
Community Based Alternatives (CBA) Waiver	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Community Living Assistance and Support Services (CLASS) Waiver	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Deaf Blind with Multiple Disabilities Waiver (DB-MD)	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Medically Dependent Children Program (MDCP)	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Home and Community Services (HCS) Waiver	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Texas Home Living Waiver (TxHmL)	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).
Consolidated Waiver Program (CWP) - Bexar County/San Antonio Only	For information on waiver services and eligibility for this waiver, contact the Department of Aging and Disability Services (DADS).

Care Improvement Plus benefits are detailed in Section 2.

Beneficiary Cost-Sharing Protections

The Plan shall not impose cost-sharing requirements on specified dual-eligible individuals, full benefit dual-eligibles, and qualified Medicare beneficiaries that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the dual-eligible SNP.





# CARE IMPROVEMENT PLUS

---

## *Medicare/Medicaid Special Needs Plan*

540 Oak Centre Drive, Suite 150  
San Antonio, TX 78258

For full information on Care Improvement Plus Dual Advantage (Regional PPO) benefits, call:

### *Current Members*

7 days-a-week, 8:00 am – 8:00 pm  
1-800-204-1002 (TTY: 1-800-713-1603)

### *Prospective Members*

7 days-a-week, 8:00 am – 8:00 pm  
1-800-711-1656 (TTY: 1-800-713-1603)

Visit us on the web [www.careimprovementplus.com](http://www.careimprovementplus.com)

Care Improvement Plus is a Medicare Advantage organization with a Medicare contract.

The Care Improvement Plus contract with CMS is renewed annually and coverage availability beyond the end of the current contract year is not guaranteed.

This document is available in other formats. Contact the plan for more details at 1-800-204-1002 (TTY: 1-800-713-1603) 7 days-a-week, 8:00 am – 8:00 pm.