



2010 Summary of Benefits

Medicare Advantage Plan (Regional PPO)



CARE IMPROVEMENT PLUS

Medicare Advantage Preferred Provider Organization



Introduction to the Summary of Benefits

CARE IMPROVEMENT PLUS MEDICARE 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 Medicare 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). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Care Improvement Plus Medicare 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 Medicare 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.

You may be able to join or leave a plan only at certain times. Please call Care Improvement Plus Medicare 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 Medicare 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 Medicare 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 Medicare Advantage (Regional PPO)?

You can join Care Improvement Plus Medicare 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 are generally not eligible to enroll in Care Improvement Plus Medicare Advantage (Regional PPO) unless they are members of our organization and have been since their dialysis began.

See page 25 for information about Who Is Eligible To Join?

CAN I CHOOSE MY DOCTORS?

Care Improvement Plus Medicare 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. Our customer service number is listed at the end of this introduction.

See page 25 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 Medicare 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 Medicare 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. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Care Improvement Plus Medicare 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.

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 Medicare 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 (800) 252-9240.

As a member of Care Improvement Plus Medicare 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 (800) 252-9240.

See page 25 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 Medicare 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 Medicare 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 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 users call (1-800-713-1603), 7 days-a-week, 8:00 am and 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 Medicare Advantage (Regional PPO).

Visit us at www.careimprovementplus.com or, call us:

Customer Service Hours: 7 days-a-week, 8:00 am - 8:00 pm

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 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

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
|---|--|--|
| IMPORTANT INFORMATION | | |
| <p>1. Premium and Other Important Information</p> | <p>Most Medicare beneficiaries will continue to pay the same \$96.40 Part B premium amount in 2010 and the yearly deductible amount is \$155.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> | <p>General \$33 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit. This limit includes only Medicare-covered services.</p> <p>Out-of-Network \$3,400 out-of-pocket limit. This limit includes only Medicare-covered services.</p> <p>In and Out-of-Network \$3,400 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 23 for information about Premium and Other Important Information.</i></p> |
| <p>2. Doctor and Hospital Choice (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>In-Network No referral required for network doctors, specialists, and hospitals.</p> |

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

INPATIENT CARE

3. Inpatient Hospital Care

(Includes Substance Abuse and Rehabilitation Services)

In 2010 the amounts for each benefit period are:
 Days 1–60: \$1,100 deductible
 Days 61–90: \$275 per day
 Days 91–150: \$550 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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

In-Network

For Medicare-covered hospital stays:
 Days 1 - 10: \$295 copay per day
 Days 11 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:
 Days 1 - 60: \$0 copay per day

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

For hospital stays:
 Days 1 - 10: \$295 copay per day
 Days 11 - 90: \$0 copay per day

See page 23 for information about Inpatient Hospital Care.

4. Inpatient Mental Health Care

Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).
 190 day lifetime limit in a Psychiatric Hospital.

In-Network

\$1,000 copay for each Medicare-covered hospital stay.

Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:
 Days 1 - 60: \$0 copay per day

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.

Out-of-Network

\$1,000 copay for each hospital stay.

See page 23 for information about Inpatient Mental Health Care.

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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| <p>5. Skilled Nursing Facility (SNF) (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: \$137.50 per day 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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: Days 1 - 20: \$0 copay per day Days 21 - 100: \$130 copay per day</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network For each SNF stay: Days 1 - 20: \$0 copay per SNF day Days 21 - 100: \$130 copay per SNF day</p> |
| <p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>\$0 copay.</p> | <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered home health visit.</p> <p>Out-of-Network 30% for home health visits.</p> |
| <p>7. Hospice</p> | <p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p> | <p>General You must get care from a Medicare-certified hospice.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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OUTPATIENT CARE

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| <p>8. Doctor Office Visits</p> | <p>20% coinsurance</p> | <p>General See "Physical Exams," for more information.</p> <p>In-Network \$25 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$40 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$25 copay for each primary care doctor visit.</p> <p>\$40 copay for each specialist visit.</p> |
| <p>9. Chiropractic Services</p> | <p>Routine care not covered</p> <p>20% 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>In-Network \$40 copay for each Medicare-covered visit.</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>Out-of-Network \$40 copay for chiropractic benefits.</p> |
| <p>10. Podiatry Services</p> | <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> | <p>In-Network \$40 copay for each Medicare-covered visit.</p> <p>\$0 copay for up to 6 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$0 to \$40 copay for podiatry benefits.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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| 11. Outpatient Mental Health Care | 45% coinsurance for most outpatient mental health services. | <p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered individual therapy visit. \$25 copay for each Medicare-covered group therapy visit.</p> <p>Out-of-Network \$25 to \$40 copay for Mental Health benefits. \$25 to \$40 copay for Mental Health benefits with a psychiatrist.</p> |
| 12. Outpatient Substance Abuse Care | 20% coinsurance | <p>In-Network \$40 copay for Medicare-covered individual visits. \$25 copay for Medicare-covered group visits.</p> <p>Out-of-Network \$25 to \$40 copay for outpatient substance abuse benefits.</p> |
| 13. Outpatient Services/Surgery | 20% coinsurance for the doctor 20% of outpatient facility charges | <p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit. \$150 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$150 copay for ambulatory surgical center benefits. \$150 copay for outpatient hospital facility benefits.</p> |
| 14. Ambulance Services (medically necessary ambulance services) | 20% coinsurance | <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$150 copay for ambulance benefits.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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| <p>15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p> | <p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>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.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> | <p>General</p> <p>\$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p><i>See page 23 for information about Emergency Care.</i></p> |
| <p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p> | <p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> | <p>General</p> <p>\$35 copay for Medicare-covered urgently needed care visits.</p> <p><i>See page 23 for information about Urgently Needed Care.</i></p> |
| <p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> | <p>20% coinsurance</p> | <p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$40 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$40 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network</p> <p>\$40 copay for Occupational Therapy benefits.</p> <p>\$40 copay for Physical and/or Speech/Language Therapy visits.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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OUTPATIENT MEDICAL SERVICES AND SUPPLIES

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| <p>18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p> | <p>20% coinsurance</p> | <p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 40% of the cost for durable medical equipment.</p> |
| <p>19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p> | <p>20% coinsurance</p> | <p>General Authorization rules may apply.</p> <p>In-Network 35% of the cost for Medicare-covered items.</p> <p>Out-of-Network 35% of the cost for prosthetic devices.</p> |
| <p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p> | <p>20% 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>In-Network</p> <ul style="list-style-type: none"> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. <p>Out-of-Network</p> <ul style="list-style-type: none"> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. |

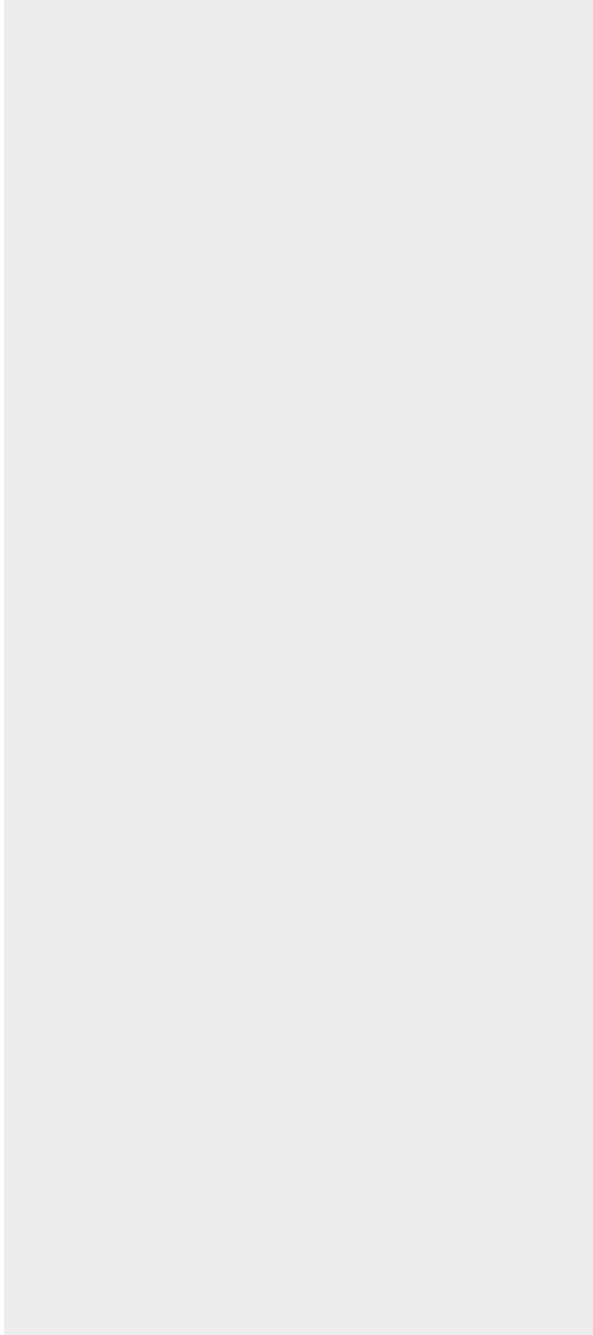
| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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| <p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p> | <p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered 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>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered lab services. 20% of the cost for Medicare-covered diagnostic procedures and tests. 20% of the cost for Medicare-covered X-rays. 20% of the cost for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services. 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays. 20% of the cost for diagnostic radiology services</p> <p><i>See page 23 for information about Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.</i></p> |
| PREVENTIVE SERVICES | | |
| <p>22. Bone Mass Measurement (for people with Medicare who are at risk)</p> | <p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p> | <p>In-Network \$0 copay for Medicare-covered bone mass measurement</p> <p>Out-of-Network \$0 copay for Medicare-covered bone mass measurement.</p> |
| <p>23. Colorectal Screening Exams (for people with Medicare age 50 and older)</p> | <p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p> | <p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network \$0 copay for colorectal screenings.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
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| <p>24. Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p> | <p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p> | <p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p> <p>Out-of-Network \$0 copay for immunizations.</p> |
| <p>25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p> | <p>20% coinsurance</p> <p>No referral needed.</p> <p>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.</p> | <p>In-Network \$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network \$0 copay for screening mammograms.</p> |
| <p>26. Pap Smears and Pelvic Exams (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>20% coinsurance for Pelvic Exams</p> | <p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>Out-of-Network \$0 copay for pap smears and pelvic exams.</p> |
| <p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p> | <p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p> | <p>In-Network \$0 copay for Medicare-covered prostate cancer screening</p> <p>Out-of-Network \$0 copay for prostate cancer screening.</p> |

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
|------------------------------------|---|--|
| 28. End-Stage Renal Disease | <p>20% coinsurance for renal dialysis</p> <p>20% 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>In-Network</p> <p>20% of the cost for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p>Out-of-Network</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>20% of the cost for renal dialysis.</p> |
| 29. Prescription Drugs | <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>Drugs covered under Medicare Part B</p> <p>General</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>20% of the cost for Part B drugs out-of-network.</p> <p><i>See page 23 for information about Prescription Drugs.</i></p> <p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.careimprovementplus.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). |

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

29. Prescription Drugs
(continued)



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).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Care Improvement Plus Medicare Advantage (Regional PPO) for certain drugs.

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 Medicare Advantage (Regional PPO) approves the exception, you will pay Formulary Non-Preferred Brand cost-sharing for that drug.

In-Network

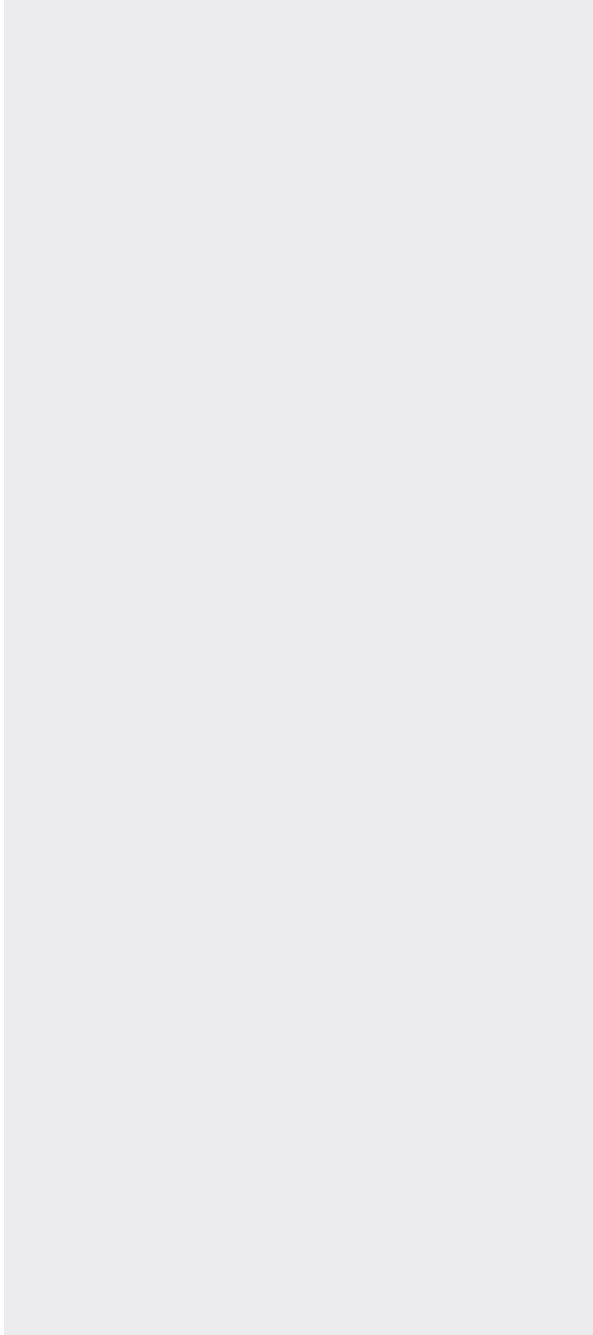
\$0 deductible

Initial Coverage

You pay the following until total yearly drug costs reach \$2,830:

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

29. Prescription Drugs
(continued)



Retail Pharmacy
Formulary Generic
 -\$9 copay for a one-month (30-day) supply of drugs in this tier
 -\$27 copay for a three-month (90-day) supply of drugs in this tier
 Formulary Preferred Brand
 -\$39 copay for a one-month (30-day) supply of drugs in this tier
 -\$117 copay for a three-month (90-day) supply of drugs in this tier
 Formulary Non-Preferred Brand
 -\$95 copay for a one-month (30-day) supply of drugs in this tier
 -\$285 copay for a three-month (90-day) supply of drugs in this tier
 Formulary Specialty
 -33% coinsurance for a one-month (30-day) supply of drugs in this tier
 -33% coinsurance for a three-month (90-day) supply of drugs in this tier

Long Term Care Pharmacy
Formulary Generic
 -\$9 copay for a one-month (31-day) supply of drugs in this tier
 Formulary Preferred Brand
 -\$39 copay for a one-month (31-day) supply of drugs in this tier
 Formulary Non-Preferred Brand
 -\$95 copay for a one-month (31-day) supply of drugs in this tier
 Formulary Specialty
 -33% coinsurance for a one-month (31-day) supply of drugs in this tier

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

29. Prescription Drugs
(continued)

Mail Order Pharmacy
Formulary Generic

- \$9 copay for a one-month (30-day) supply of drugs in this tier
- \$22.50 copay for a three-month (90-day) supply of drugs in this tier

Formulary Preferred Brand

- \$39 copay for a one-month (30-day) supply of drugs in this tier
- \$97.50 copay for a three-month (90-day) supply of drugs in this tier

Formulary Non-Preferred Brand

- \$95 copay for a one-month (30-day) supply of drugs in this tier
- \$237.50 copay for a three-month (90-day) supply of drugs in this tier

Formulary Specialty

- 33% coinsurance for a one-month (30-day) supply of drugs in this tier
- 33% coinsurance for a three-month (90-day) supply of drugs in this tier

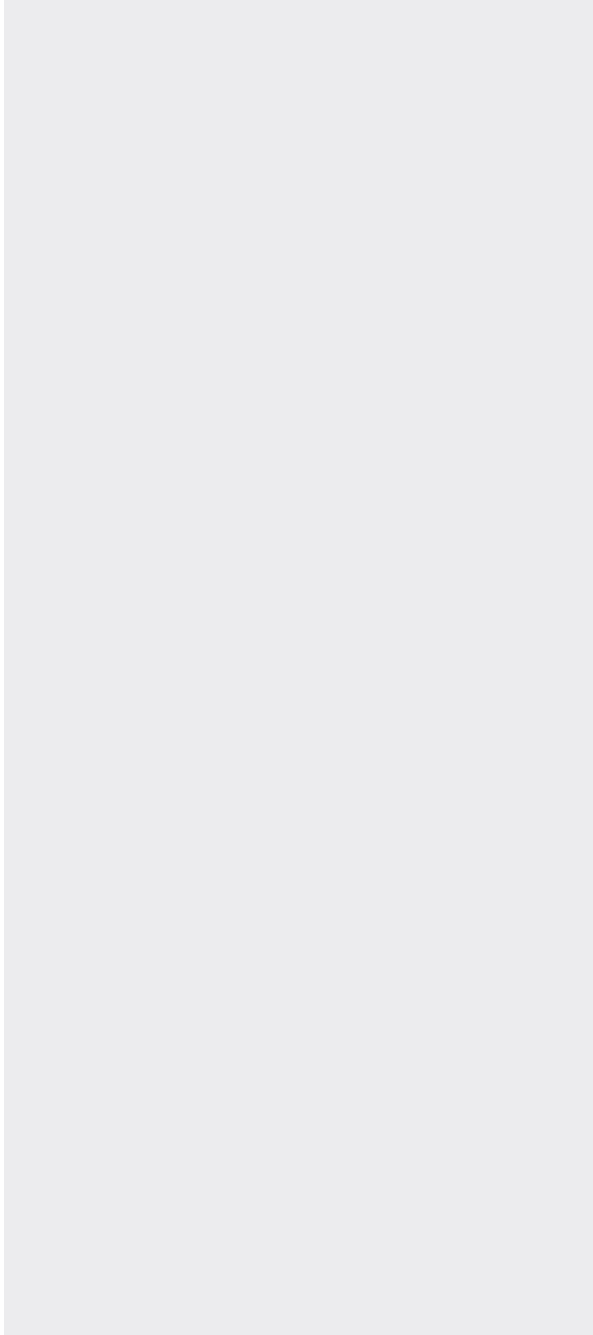
Coverage Gap
After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage
After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or
- 5% coinsurance.

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

29. Prescription Drugs
(continued)



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 Medicare Advantage (Regional PPO).

Out-of-Network Initial Coverage
You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:

Formulary Generic
- \$9 copay for a one-month (30-day) supply of drugs in this tier

Formulary Preferred Brand
- \$39 copay for a one-month (30-day) supply of drugs in this tier

Formulary Non-Preferred Brand
- \$95 copay for a one-month (30-day) supply of drugs in this tier

Formulary Specialty
- 33% coinsurance for a one-month (30-day) supply of drugs in this tier

Out-of-Network Coverage Gap
After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Care Improvement Plus Medicare Advantage (Regional PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Care Improvement Plus Medicare Advantage (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
|--|--|--|
| 29. Prescription Drugs (continued) | | <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> -A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or -5% coinsurance. |
| 30. Dental Services | Preventive dental services (such as cleaning) not covered. | <p>In-Network \$0 copay for Medicare-covered dental benefits.</p> <p>\$10 copay for an office visit that includes:</p> <ul style="list-style-type: none"> - 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>Out-of-Network \$0 copay for comprehensive dental benefits. \$10 copay for preventive dental benefits.</p> <p><i>See page 24 for information about Dental Services.</i></p> |
| 31. Hearing Services | Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. | <p>In-Network In general, routine hearing exams and hearing aids not covered. \$40 copay for Medicare-covered diagnostic hearing exams</p> <p>Out-of-Network \$40 copay for hearing exams.</p> |

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

| | | |
|-----------------------------------|---|---|
| <p>32. Vision Services</p> | <p>20% 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>In-Network</p> <ul style="list-style-type: none"> - \$10 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$10 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year - \$0 copay for glasses - \$0 copay for contacts <p>\$150 limit for eye wear every year.</p> <p>Out-of-Network</p> <ul style="list-style-type: none"> \$0 copay for eye wear. \$10 copay for eye exams. \$10 copay for eye wear. <p><i>See page 24 for information about Vision Services.</i></p> |
|-----------------------------------|---|---|

| | | |
|----------------------------------|--|---|
| <p>33. Physical Exams</p> | <p>20% 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>In-Network</p> <ul style="list-style-type: none"> \$0 copay for routine exams. <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network</p> <ul style="list-style-type: none"> \$0 copay for routine exams. |
|----------------------------------|--|---|

| Benefit | Original Medicare | Care Improvement Plus Medicare Advantage (Regional PPO) |
|----------------------------------|--|---|
| Health/Wellness Education | 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>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Additional Smoking Cessation - Nursing Hotline - Other Wellness Benefits <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>Out-of-Network \$0 copay for Health and Wellness services.</p> <p><i>See page 24 for information about Health/Wellness Education.</i></p> |
| Transportation (Routine) | Not covered. | <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 12 one-way trip(s) to plan-approved location every year.</p> <p>Out-of-Network \$0 copay for transportation.</p> <p><i>See page 24 for information about Transportation.</i></p> |
| Acupuncture | Not covered. | <p>In-Network This plan does not cover Acupuncture.</p> |

Section III

Clarification to Benefits in Section II

In- and Out-of-Network

All cost sharing is the same in- and out-of-network with the exception of Durable Medical Equipment and Home Health.

1 Premium and Other Important Information

In- and Out-of-Network

\$3,400 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 Medicare Advantage Plan, you'll pay \$50 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 denture adjustments, periodic exams, cleanings and X-rays.

You will pay \$10 for routine preventive office visits which include:

- 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)
- Denture adjustments (2 of any 4 denture adjustments per year)

32 Vision Services

In- and Out-of-Network

Your vision coverage includes:

\$10 copay for one pair of eyeglasses or contact lenses after cataract surgery

\$10 copay for exams to diagnose and treat diseases and conditions of the eye

\$10 copay for up to 1 routine eye exam every year

\$150 limit for eye wear every year

33 Transportation

In- and Out-of-Network

You will have a \$0 copay for up to 12 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 Care Improvement Plus Medicare Advantage (Regional PPO)?

Care Improvement Plus Medicare 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 and enrolled in Part B. 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 Medicare Advantage (Regional PPO) offers an open access provider network — you may go to any Medicare-approved provider who will accept payment from our plan . 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. 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



CARE IMPROVEMENT PLUS

Medicare Advantage Preferred Provider Organization

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

For full information on Care Improvement Plus Medicare 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

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.