Out of Network Coverage

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today's Options® PFFS, Today's Options® PPO, and Today's Options® HMO (hereinafter, the Plan) has a network of providers. The Plan contracts with network providers for all services covered under Original Medicare. The Plan will generally cover your medical care provided that:

- The care you receive is part of the plan's Medical benefits and pre-authorization guidelines are followed. For a complete list of plan benefits, please refer to the plan Evidence of Coverage.
- The care you receive is considered medically necessary and is a recognized and accepted treatment for the medical condition you receive care for.
- The care you receive is from a provider who participates in Medicare.
- Additional information, by plan type is as follows:

    - **For HMO and HMO-SNP Plans:**
        - In most cases, before you can receive care from other providers in the network (such as specialists, hospitals, or skilled nursing facilities), your PCP must provide approval.
        - You have a Primary Care Physician (PCP) who provides and oversees your care.
        - You must use plan providers except in emergency or urgent care situations or for out-of-area dialysis. If you obtain routine care from out-of-network providers, neither Medicare nor the Plan will be responsible for the costs.

    - **For HMO-POS Plans:**
        - The Plan has established a network of providers that are contracted to provide medical services. With the HMO-POS plan, you also have the option of seeing an out-of-network provider, provided that those providers accept Medicare assignment.
        - When you choose to see an out-of-network provider, you do not need to obtain a referral or an authorization. Out-of-network providers must choose to accept the HMO-POS plan members as patients.
        - The care you receive from an out-of-network provider is covered under the POS Benefit. The cost share that you incur will be higher for most services.
        - Durable Medicare Equipment (DME), Home Health and Skilled Nursing Facility (SNF) admits are not covered under the POS benefit and in-network providers must be used.

- **For PPO Plans:**
  - You may receive covered services from out-of-network providers (those who do not have a signed contract with our plan), provided that those providers agree to accept Medicare assignment.
  - You may be able to receive care from an out-of-network provider. However, the provider must participate in Medicare and your cost-sharing for services that are covered by the plan may be higher. If you receive care from a provider who does not participate in Medicare, you could be responsible for the full cost of services received.
  - You do not need to obtain a referral or prior authorization in order to receive care from out-of-network providers. However, we suggest calling Member Services, before you receive care and services from a provider, in order to confirm that the services are covered by the plan and are medically necessary.

- **For PFFS Plans:***
  - If your provider is not one of our network providers, then the provider is not required to agree to accept the plan's terms and conditions of payment and therefore they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on the plan website at: www.TodaysOptions.com

Emergency and Urgent Care

For all Plans: The Plan will cover dialysis, emergency and urgent care if you are outside of the plan's service area. If you use an out-of-network provider for emergency care, urgently needed care, or out-of-area dialysis, your cost-sharing will not be higher.

Additionally, for HMO Plans: Returning to the care of a network provider may be recommended as soon as your health allows.

Additionally, for PFFS Plans: Emergency and urgent care is covered whether a provider agrees to accept the plan's payment terms or not. There is no pre-authorization required for medical services but you or your provider can request a pre-authorization to ensure the services are medically necessary.

Out-of-Network Pharmacy Coverage (if you have a plan with Medicare Advantage Prescription Drug coverage)

The Plan has formed a network of pharmacies.

- The pharmacies in our network can change at any time. You may pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. To

find a network pharmacy, you can search our Pharmacy Locator or call us at the number on the back of your Member ID card for an up-to-date list. Choose whatever is easiest for you.

- Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

    - If the prescription(s) is related to care for a medical emergency or urgently needed care.
    - If the member is traveling within the United States and becomes ill, loses or runs out of his / her medication. NOTE: The organization cannot reimburse the member for any prescription(s) that is filled by a pharmacy outside of the United States - even in emergencies.
    - If you are unable to obtain covered drugs in a timely manner within the service area and there is not a network pharmacy within a reasonable driving distance that provides 24 hour service.
    - If you need to obtain a covered drug that is not regularly stocked at an accessible pharmacy.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You then have to ask us to reimburse you for our share of the cost.

Visit the Plan Materials page under For Members on the plan website to find and download a claim form for a Part D covered medication dispensed by an out-of-network pharmacy.

*Our plans have an established network of providers (that is, providers that have signed contracts with our plan) for all services covered under Original Medicare. These providers have agreed to our terms and conditions and to see members of our plan.

TexanPlus® HMO, TexanPlus® HMO-POS, Today's Options® PPO, and Today's Options® PFFS, and Today's Options® HMO are Medicare Advantage plans with a Medicare contract. Enrollment in these plans depends on contract renewal. A Private Fee-for-Service plan is not Medicare supplement insurance. Providers who do not contract with our plan are not required to see you except in an emergency. Out-of-network/non-contracted providers are under no obligation to treat Today's Options® PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year. We also list pharmacies that are in our network but are outside our service area. Please contact the Plan at the number on the back of your Member ID card, in your local time zone, 7 days a week, for additional information. TexanPlus® HMO-SNP is a Medicare Advantage plan with a Medicare contract and a contract with the State Medicaid Program. Enrollment in TexanPlus® HMO-SNP depends on contract renewal. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.