CARE

RAILROAD HEALTHCARE

Serving Current and Former BNSF Railroaders

HEALTH CARE PREPAYMENT PLAN
&
MEDICARE SECONDARY PLAN
BENEFIT GUIDE

Celebrating More Than 130 Years of Excellence

EFFECTIVE JANUARY 1, 2016

Introduction

CARE was developed from the original charter of the Gulf Colorado Employees Hospital Association in 1891 and the Atchison Railroad Employes' Association organized in 1884. Changes have been made through the years to respond to the needs and wishes of the members and as a result, on July 1, 1996, the Santa Fe Employees Hospital Association and the A. T. & S. F. Employes' Benefit Association merged and formed the Consolidated Associations of Railroad Employees (**CARE**).

Read your **CARE** Medicare Secondary Plan Benefit Guide carefully and keep it where it can be found for reference. **CARE** will furnish additional copies at any time upon request. Your current **CARE** Medicare Secondary Plan Benefit Guide contains revisions which greatly enhance the coverage provided to the membership by this Association. For your own benefit, we urge you to read the **CARE** Medicare Secondary Plan Benefit Guide so that you will be aware of the benefits provided and the proper procedures to follow if the need should arise.

FOR QUESTIONS YOU MAY HAVE REGARDING
BENEFIT COVERAGE, MEMBERSHIP AND ELIGIBILITY, CLAIMS INQUIRIES, PROVIDER INFORMATION
CALL THE:

CARE Office
Temple, Texas

Local Number 254.773.1330

Toll-free Number 1.800.334.1330

Claims Fax Number 254.774.7652

TTY / TDD users call 711 for all states

Si necesita asistencia en Español, por favor llame al 254.773.1330, llamadas gratis llame al 800.334.1330

CARE Web Site ..... www.carehealthplan.com

OTHER IMPORTANT TELEPHONE NUMBERS

PLAN #4000 MEMBERS ONLY
***Express Scripts Medicare* PDP** - Medicare Prescription Drug Plan (Part D) 1.866.725.2511
TTY / TDD Users 1.800.716.3231

PLAN #4100 MEMBERS ONLY
Employer Health Options Help Desk (EHO Discount Drug Card) 1.800.650.1817

Railroad Part B Medicare 1.800.833.4455

Railroad Retirement Board Main Number 1.877.772.5772

Social Security Administration 1.800.772.1213

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- Part 3 - Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.

➢ Appeal Level 1:
If **CARE** HCPP or the Original Medicare claims processor denies your request for coverage or payment of a service, you may ask us (or them) to reconsider the decision. This is called an appeal or request for reconsideration

➢ Appeal Level 2:
If **CARE** HCPP or the Original Medicare claims processor denies any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

➢ Appeal Level 3:
If the organization that reviews your case at appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

➢ Appeal Level 4:
Your case may be reviewed by a Medicare Appeals Council

➢ Appeal Level 5:
Your case may go to a Federal Court

SUMMARY PLAN DESCRIPTION

Plan Name: Consolidated Associations of Railroad Employees (**CARE**) formerly the Santa Fe Employees Hospital Association and the A. T. & S. F. Employes' Benefit Association

Plan Sponsor: Consolidated Associations of Railroad Employees Health Care Trust Fund
4912 Midway Drive
P. O. Box 6130
Temple, Texas 76503-6130

Employer Identification Number: 75-6493465

Administration of Plan: The Plan is administered by Consolidated Associations of Railroad Employees, 4912 Midway Drive, Temple, Texas 76502 and any obligations created hereunder are performable in Bell County, Texas. **CARE** is NOT an insurance company and benefits provided to the members of this private entity are NOT insurance benefits and are NOT subject to assignment to doctors or hospitals except upon written approval of **CARE**.

Plan Year: January 1 through December 31

Plan Contributions and Funding: The Plan is funded by membership contributions, through a monthly dues assessment. It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Members may remit dues monthly, quarterly or yearly direct to **CARE**. Bank draft is available for your convenience. Members will be notified in writing of any dues increase in connection with their Plan.

Plan Purpose: The purpose for which this Trust was formed was for the support of a benevolent and charitable undertaking in this: To provide for medical services for the employees and former employees of the Burlington Northern Santa Fe Railway Company, the A. T. & S. F. Railway Company and the Gulf, Colorado and Santa Fe Railway Company, employees of unions that represent Railway employees, individuals, or employees of other companies which the Board of Directors may from time to time decide to admit to said **CARE**. Such service and care will be furnished in accordance with such rules and regulations as may from time to time be approved by the Board of Directors, provided, that at all times **CARE** shall conduct itself strictly as a nonprofit, charitable and benevolent organization and in compliance with all applicable provisions of Section 501(c)(9) of the Internal Revenue Act of 1954, as same may be amended, or the comparable section of any future Revenue Act.

The benefits provided by **CARE** are payable to the member or in the event of the member's death before payment, to the member's estate. The benefits are not subject to the liens of, or assignment to, any physician or healthcare providers except upon **CARE**'s written agreement.

All benefits are subject to the definition, limitations, and exclusions in this brochure and are payable when determined by the Plan to be medically necessary. Coverage is provided only for services and supplies which are listed in this brochure. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.

All benefits are based upon reasonable and customary charges. Those charges are compared with charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area and which meet the Plan's established guidelines for that area. The Plan's guidelines have been developed statistically from actual claims received in each zip code area throughout the United States and are updated annually.

No one is authorized to contract any indebtedness against **CARE** in any manner other than as provided in these Rules and Benefits, except upon the written authority of **CARE**.

Summary of Material Modifications (SMM): The SMM is required anytime there is "material modification" in the terms of the plan or any change in the information required to be in the plan booklet. Material modifications include amendment provisions that establish new benefits, take away existing benefits, narrowing or expansion of the circumstances under which benefits are paid and should the plan terminate entirely. In addition, the SMM must be provided on a more accelerated basis for any "material reduction" in covered services or benefits provided under the plan. Should benefits be amended, reduced or eliminated, a summary of any provisions governing the benefits, rights and obligations of participants under the plan upon termination or amendment of the plan will be provided to participants.

Membership: Membership in **CARE**, as defined within this Plan, does not confer any voting right upon any person referred to as a "Member." **CARE** Bylaws confer the right to vote upon all **CARE** business on the Board of Directors. A copy of the current Bylaws is available to members upon written request to the Chief Executive Officer.

ELIGIBILITY AND PARTICIPATION

Medicare Eligibility: Eligible persons may enroll for Medicare coverage (during the period that starts three months before the effective date of your Medicare coverage and ends three months after the effective date of your Medicare coverage). Individuals must be enrolled in Hospital (Part A) and Medical (Part B) coverage under Medicare to be eligible for **CARE** coverage. Medicare coverage consists of Part A, which pays for hospital services, Part B, which pays for physician and other medical services and Part D which is the prescription drug program.

An eligible retiree and/or former retiree, spouse, ex-spouse or surviving spouse becomes eligible under Medicare:

- On the first day of the month in which he or she attains age 65 (if an individual's birthday is on the first day of the month, he is considered to reach 65 the first day of the previous month); or

- Before age 65 by meeting the disability requirements established by the Railroad Retirement Board and/or the Social Security Administration.

For additional information regarding Medicare entitlement members should contact the Railroad Retirement Board Office and/or the Social Security Administration.

Membership Availability: Medicare supplemental plans are available to the following people:

- current and former Atchison, Topeka and Santa Fe and/or Burlington Northern Santa Fe employees
- current and former Santa Fe Employee Hospital Association (SFEHA) and Atchison, Topeka & Santa Fe Employes' Benefit Association (EBA) employees and members
- Medicare spouse or ex-spouse of **CARE** member
- Medicare widow(er) of **CARE** member
- disabled child on Medicare and/or
- individuals and employees of other companies which the Board of Directors may from time to time decide to admit to **CARE**.

Enrollment: Anyone who wishes to participate in one of the Medicare supplemental plans must complete and submit an application. By signing the Medicare supplemental form, all applicants authorize the Centers for Medicare & Medicaid Services (CMS) to provide **CARE** with information concerning their entitlement

to Medicare and their Part B claims history. Persons with current membership are eligible to enroll in a Medicare supplemental plan upon becoming eligible for Medicare and remitting a copy of their Medicare card to **CARE**. Eligible persons without a current connection may apply for membership during an Open Enrollment. Persons interested in applying for membership should contact **CARE**.

An eligible dependent spouse or surviving spouse MUST be enrolled in Medicare Parts A & B and remain enrolled to receive benefits from **CARE**. The eligible dependent or surviving spouse may enroll for membership by making application direct to **CARE**. The application for membership must be accompanied by a copy of his or her Medicare Parts A & B card.

If you are eligible for Medicare and are employed, or your spouse is employed and has you covered for health care benefits under his or her employer plan, the employer plan is primary; Medicare is secondary, and **CARE** is third payer.

Health Care Prepayment Plan (HCPP): CARE contracts with the Centers for Medicare and Medicaid Services (CMS), the agency in the Federal Government that administers Medicare, to be a Health Care Prepayment Plan (HCPP). An HCPP provides or arranges for some or all of Part B Medicare Benefits on a prepayment basis. All of our Medicare Plan members are automatically enrolled in our HCPP.

The HCPP contract is automatically renewed for successive one year periods unless **CARE** or CMS gives written notice of intention not to renew the contract at least 90 days before the end of the current period, or if CMS finds that **CARE** failed to perform its obligations under the agreement or undergoes a change of ownership, CMS may terminate or not renew the agreement after giving **CARE** the prescribed notice stating the reason for the termination or non renewal and effective date thereof.

Payment of Dues: It is the member's responsibility to ensure that dues are properly remitted to **CARE**. Dues may be remitted on a monthly, quarterly or yearly basis. Bank draft is available for your convenience.

Disenrollment

Voluntary Disenrollment: A member may withdraw from **CARE** at any time for any reason by giving us written notification of your desire to disenroll. Membership will terminate at the end of the month in which **CARE** receives the notice. Disenrollment form is located in the back of this booklet.

Involuntary Disenrollment: Disenrollment from **CARE** and HCPP plans does not affect your enrollment in Medicare Part A & B. Termination of membership in **CARE** will occur if:

- Enrollment in Medicare Part A or Part B ends
- Member fails to make the required membership dues payment within the 30-day grace period
- Providing **CARE** with inaccurate or fraudulent information upon enrollment
- Not abiding by regulations of **CARE**
- Improper use of your Medicare or **CARE** insurance card
- Upon the death of a member, membership will terminate at the end of the month in which the member expired. Upon receipt of written proof, dues paid in advance of this date will be refunded to the spouse of the person, or the executor of the estate.
- Inappropriate or disruptive behavior to our staff or other members

CARE Identification Card: Members will be issued a **CARE** identification card upon enrollment. As an HCPP participant, this should be presented with your Railroad Medicare card and/or Social Security Medicare card at each office visit and each hospital visit. To receive benefits, members may identify themselves by showing their **CARE** identification card.

Open Enrollment: A date determined by the **CARE** Board of Directors allowing former or retired Railway employees, spouses, or dependents to enroll for membership. Notification of an Open Enrollment will normally be announced in the **CARE** newsletter, or by a notice sent to current members of **CARE**, or to persons who have requested membership in **CARE**. Membership in **CARE** is based on the primary or sponsoring member having or having had an employment connection with the Atchison Topeka and Santa Fe or Burlington Northern Santa Fe Railway Company, individuals, and employees of other companies which the Board of Directors may from time to time decide to admit to **CARE**. Individuals eligible to enroll as members of **CARE** must complete an application for membership which will be furnished by the **CARE**. Eligible dependents may request membership in **CARE** during one of the following:

- upon becoming eligible for Medicare coverage
- within 30 days of getting married
- during an open enrollment

The plan year for **CARE** Medicare members is January 1 through December 31. New members enrolling in either Plan #4000 or Plan #4100 must remain enrolled in their selected plan through December 31.

Open Enrollment for Current CARE Members: As a reminder, the plan year for current **CARE** Medicare members is January 1 through December 31. Current **CARE** members must remain enrolled in their selected plan through December 31. **CARE** members will be given the opportunity to make a plan selection from October 15 through December 7 this year to be effective January 1 of the following year.

PLAN OUTLINE

Plan #4000: Supplement to Medicare Parts A & B with Medicare Part D Prescription Drug coverage administered by *Express Scripts Medicare* PDP

- Freedom to go to any doctor or hospital that accepts Medicare **(Topeka members see below)***
- Supplements your Medicare coverage and covers most services paid by Medicare****
- Full payment of the Medicare deductibles and/or coinsurance amounts for covered services rendered by providers participating with Medicare
- No copayments for doctor office visits or emergency room visits
- Medicare Part D Prescription Drug coverage which covers all Part D eligible drugs
- No Part D Prescription Drug deductible
- Option of Mail-order Pharmacy or use of any participating retail pharmacy for Part D Prescription Drug coverage

Plan #4100: Supplement to Medicare Parts A & B Only

- Freedom to go to any doctor or hospital that accepts Medicare **(Topeka members see below)***
- Supplements your Medicare coverage and covers most services paid by Medicare****
- Full payment of the Medicare deductibles and/or coinsurance amounts for covered services rendered by providers participating with Medicare
- No copayments for doctor office visits or emergency room visits

***** *Unless listed as an Exclusion on page 14***

***Topeka Medicare Member:** **CARE** Medicare members living in Topeka, Kansas and having an address with a zip code beginning with the numbers **"666" MUST** have a primary care physician at the St. Francis Medical Clinic/River Hill located at 6001 S. W. 6th Ave or St. Francis Medical Clinic/Hunters Ridge located at 4646 NW Fielding Road to receive covered benefits. In order to receive coverage for the services of a specialist, you must obtain a referral from your primary care physician. Outpatient testing not available at

either of the St. Francis Medical Clinics may be scheduled elsewhere at the direction of the primary or consulting physician. **For any required medical services outside regular office hours, the Medicare member should call 785.232.4248 for the physician on-call.**

CARE's HCPP contract with CMS allows **CARE** to act as a Medicare Part B Intermediary and pay both the Medicare primary and the **CARE** secondary parts of Medicare Part B claims at one time to **CARE** contracted participating physicians and Medicare Part B providers. By participating, the physician or provider of Medicare Part B services does not have to bill Medicare and then bill **CARE** for the portion Medicare does not pay (secondary billing). Thus, **CARE** can make the complete payment for the following services:

- Doctor Office Visits / Consultations
- Hospital Visits
- X-rays and Surgical Procedures

CARE HCPP participating providers can bill **CARE** at the Medicare Limiting Charge or bill **CARE** using their normal fee for service fee schedule and **CARE** will reduce the charges to the Medicare Limiting Charge. **CARE** will pay for certain charges not covered by Medicare Part B provided the charges fall within the **CARE** benefit structure.

Services Required Outside the United States: Medicare members must comply with Medicare's criteria before secondary payment can be made. Currently, Medicare does not pay for services received out of the United States, except in Canada and Mexico in emergency instances.

How to File Medical Supplemental Claims for Plan #4000 and Plan #4100: To ensure proper payment of your medical claims, you or your provider must supply **CARE** with an itemized statement and the Explanation of Medicare Benefits (EOMB) that is received from the primary carrier. All data must be printed out on paper and include the following information:

- Patient's full name, social security number and/or **CARE** identification number
- ICD-10 codes (diagnosis codes)
- CPT-4 codes (procedure codes)
- Must have billed amount and allowed amount for each CPT-4 code
- Date(s) of service
- Name, address, tax identification number of physician or institution providing services and National Provider Identifier (NPI) number

How to File Medicare HCPP Claims for Plan #4000 And Plan #4100: To ensure proper payment of your medical claims, your provider must supply **CARE** with an itemized statement on a CMS 1500 form. All data must be printed out on paper and include the following information:

- Patient's full name, social security number and/or **CARE** identification number
- ICD-10 codes (diagnosis codes)
- CPT-4 codes (procedure codes)
- Must have billed amount for each CPT-4 code
- Date(s) of service
- Name, address, tax identification number of physician or institution providing services and National Provider Identifier (NPI) number

Claims For Plan #4000 And Plan #4100 Should Be Mailed Or Faxed To:
CARE
4912 Midway Drive
P. O. Box 6130
Temple, Texas 76503-6130
Fax #: 254.774.7652

Claims Filing Deadlines:

- If the provider files your charges to Medicare first, a copy of the itemized statement and the Explanation of Medicare Benefits must be submitted as soon as possible and received by **CARE** for secondary payment no later than one (1) year from the date Medicare processed the claim. **It is your responsibility to ensure that claims are filed timely.**

- Claims filed directly to **CARE** by the provider under the HCPP contract with service dates for the prior year, must be submitted as soon as possible and received by **CARE** no later than March 15th of the current year. It is the provider's responsibility to ensure that claims are filed before the March 15th deadline.

PRESCRIPTION DRUG BENEFIT

Plan #4000 Medicare Part D Prescription Drug Benefit Administered by *Express Scripts Medicare* PDP

Deductible	**No Annual Deductible**		
Initial Coverage Stage (0-$3,310)	You will pay the applicable copayment and/or coinsurance listed below until your **total drug costs** reach $3,310.		
Coverage Gap Stage ($3,310 - $4,850)	After your **total drug costs** reach $3,310, you will continue to pay the same applicable copayment and/or coinsurance listed below as in the Initial Coverage Stage until you reach **out-of-pocket costs** of $4,850.		
COPAYMENTS	**RETAIL**		**MAIL ORDER**
	Up to 34-Day Supply	**35 to 90-Day Supply**	**90-Day Supply**
Tier 1: Generic ✻	$15	$15	$15
Tier 2: Preferred Brand Drugs	$40	$90	$70
Tier 3: Non-Preferred Brand Drugs	$60	$180	$150
Tier 4: Specialty Drugs	33% of drug costs. $300 Maximum	33% of drug costs. $900 Maximum	33% of drug costs. $750 Maximum
✻ **Reminder:** *If the cost of your generic drug is less than the $15 copayment, you will pay the lesser price. Examples: If your generic drug is $7.50, you will only pay $7.50, NOT the $15 copayment. If the cost of the generic drug is $25, you will ONLY pay the $15 copayment.*			
Catastrophic Coverage Stage > (Greater than $4,850)	After your **out-of-pocket drug costs** reach $4,850, you will pay the greater of 5% coinsurance or $2.95 for generics (*or drugs treated as generic*) and $7.40 for all other drugs. The plan will pay the rest.		

Total Drug Costs - Drug costs paid by you and the plan.

Out-of-Pocket Drug Costs - Copayment and/or coinsurance paid by you and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare, Medicare's Coverage Gap Discount Program, etc.

Does NOT include payments made for **a)** plan premiums, **b)** drugs not covered by your plan, **c)** non-Part D drugs (such as drugs you receive during a hospital stay), **d)** and drugs obtained at a non-network pharmacy that does not meet out-of-network pharmacy access policy.

Plan #4100 Consumer-Based Prescription Drug Benefit

Although Plan #4100 members **do not** have a prescription drug benefit, members in this plan are eligible to receive discounts on prescription drugs using their EHO discount drug card. This allows the member to obtain the discounted retail network price for prescriptions. To participate in the Consumer-Based Benefit and obtain discounted retail network pricing, members must purchase prescriptions at a retail pharmacy that honors the EHO discount drug card. For more information regarding this feature for Plan #4100 members, please contact **CARE** at 1.800.334.1330 or EHO at 1.800.650.1817. **Note:** ***Prescription quantity restrictions do not apply under the Consumer-Based Benefit, and it may be more economical for you to have your physician increase prescribing quantities while you are taking advantage of this added feature.***

SCHEDULE OF BENEFITS

Please refer to your current "Medicare & You" Handbook for detailed information on your benefits as* CARE *is a supplement to your Medicare benefits.

Ambulance Services: CARE will supplement up to 20% coinsurance on Medicare approved charges and will pay your Part B deductible. As a reminder, this service must be deemed medically necessary and appropriate in order for **CARE** to supplement.

Chiropractic Services: CARE will pay your Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Diabetic Supplies: Plan #4000 members must utilize their Medicare Part D Prescription Drug benefit to purchase insulin, syringes and needles.

Plan #4000 and Plan #4100: Medicare Part B currently covers certain diabetic supplies (test strips and lancets). Medicare members are encouraged to utilize a pharmacy that will submit these charges to Medicare. Once the charges have been filed and processed by Medicare, a copy of the Explanation of Medicare Benefits (EOMB) should be sent to **CARE**. **CARE** will pay the Part B deductible and supplement up to 20% coinsurance on the Medicare approved charges.

Glucometers are covered under Medicare Part B and **CARE** will supplement on these charges. Most manufacturers offer rebates directly to the consumer on glucometers that make their cost very reasonable.

Diagnostic Tests, X-rays, and Lab Services: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Durable Medical Equipment: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Emergency Care: CARE** will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges. If admitted into the hospital **CARE** will cover your Medicare Part A deductible.

***Except for certain limited cases in Canada and Mexico, Medicare does not pay for treatment outside the United States. If the treatment is not covered by Medicare, no secondary payment is due by* CARE.**

Home Health Services: Home Health Care and Treatment are defined as plans of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without the Home Health Care, confinement in a hospital would be required. **CARE** will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Hospice Benefit: To qualify for a Hospice Program, the physician must certify that the patient has a life expectancy of six (6) months or less. **CARE** will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Hospitalization: A benefit period begins on the first day you go into the hospital and ends when you have not received any hospital care for 60 consecutive days, during this period **CARE** will cover your Medicare Part A deductible. If you go to 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. **CARE** will supplement the Medicare and **CARE** approved charges. **CARE** will cover the cost of the first three pints of blood, if used and not replaced, which is your blood deductible. **(Excluding Long Term Acute Care Facility (LTAC) – see below for benefits).**

Immunizations: (Flu vaccine, Hepatitis B vaccine for people with Medicare who are at risk, and pneumonia vaccine): CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Kidney Dialysis (Outpatient): CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Long Term Acute Care Facility: CARE will pay the Medicare Part A Hospital deductible for Days 1-60 while confined in a Medicare approved Long Term Acute Care Hospital. **CARE** will not consider any Medicare coinsurance that may be due during any Long Term Acute Care Hospitalization.

Mammograms (Annual screening for women with Medicare age 40 and older): CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Mental Health: CARE will pay your Medicare Part A and Part B deductibles and will supplement up to 20% coinsurance on Medicare approved charges.

Pap Smears and Pelvic Exams: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Podiatry Services: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Prostate Cancer Screening Exam: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Prosthetic Devices (includes braces, artificial limbs and eyes, etc.): CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

Vision Services: CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges. As information, eye refractions are not covered by Medicare Part B, however, **CARE** will consider these charges for payment. Once Medicare has considered their portion of the charge, a copy of the Medicare Explanation of Benefits should be sent to **CARE** for payment of the Medicare Part B deductible and remaining coinsurance.

Organ Transplants: CARE will pay your Medicare Part A and Part B deductibles and will supplement up to 20% coinsurance on Medicare approved charges.

Outpatient Rehabilitation (Physical / Occupational / Speech Therapy): CARE will pay your Medicare Part B deductible and will supplement up to 20% coinsurance on Medicare approved charges.

GENERAL INFORMATION

Catastrophic Coverage Stage (Part D): The stage in Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,850 in covered drugs during the covered year.

Coinsurance: The percentage of each covered expense you are responsible for paying after you have met any applicable copayments and/or deductibles. Coinsurance is usually a percentage (for example, 20%).

Cost-Sharing (Part D): Cost-sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier (Part D): Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Gap Stage: (Part D): The Medicare Part D Coverage Gap (donut hole) lies between the Initial Coverage Limit and the Catastrophic Coverage stage in the Medicare Part D prescription-drug program. After a Medicare beneficiary exits the Initial Coverage of prescription-drug plan, the beneficiary is financially responsible for a higher cost of prescription drugs until he or she reaches the Catastrophic Coverage Stage. **For Plan Year 2016, Plan #4000 members will only be responsible for copayments during this stage.**

Covered Drugs (Part D): The term we use to mean all of the prescription drugs covered by our plan.

Covered Facilities: A Freestanding Ambulatory Facility is a facility which meets the following criteria: has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or other professional.

A Hospital is a facility which is:

- Accredited as a hospital under the Hospital Accreditation Program of the Joint Commission of Accreditation of Health Care Organization (JCAHO);

- Operated pursuant to law, under the supervision of a staff of doctors, and with 24-hour a day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; and

- Medicare approved.

In no event shall the term "Hospital" include a convalescent nursing home or any institution or part thereof, which (a) is used principally as a convalescent facility, nursing facility, or facility for the aged; (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living. Likewise, the term "Hospital" shall not include any institution or part thereof which constitutes a skilled nursing facility.

Covered Providers: Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), Doctors of Podiatric Medicine (D.P.M.), Doctors of Surgical Chiropody (D.S.C.), Doctors of Optometry (D.O.), Doctors of Chiropractic (D.C.), and Doctors of Psychology (Ph.D), Physicians' Assistants (P.A.), Nurse Practitioners, Licensed Clinical Social Workers (L.C.S.W.) when the services they provide are within the benefits included in this health program and when they are practicing within the scope of their license or certification.

Deductible: The amount you must pay for covered services each year before the plan begins to pay benefits. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change each year. **CARE** Plan #4000 and Plan #4100 pay your Medicare Part A and B deductibles. Also, there is no deductible for the Plan #4000 Part D Prescription Drug Benefit.

Generic Drug (Part D): A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, generic drugs cost less than brand name drugs.

GINA (Genetic Information Nondiscrimination Act): This rule outlines the requirements that health plans must follow to comply with the nondiscrimination provisions of HIPAA. GINA prohibits group health plans from adjusting group premium or contribution amounts on the basis of genetic information. In addition, GINA prohibits group health plans and health insurers from denying coverage to a healthy individual or charging a person a higher premium based solely on a genetic predisposition to developing a disease or disorder.

Health Insurance Portability And Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to mail certificates of creditable coverage to individuals who lose coverage under the plan. The Health Insurance Portability and Accountability Act of 1996 limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for late enrollees).

The 12-month (or 18-month) exclusion period is reduced by your days of creditable coverage under prior health coverage. A period of prior creditable coverage will be disregarded if you have a 63-day or longer break in creditable coverage after that period, excluding any waiting period for coverage or any period during which an individual's application for coverage was pending. You are entitled to a certificate that will show evidence of your prior health coverage. We will assist you, if necessary, in determining the amount of your prior creditable coverage, and in obtaining information, such as a certificate of creditable coverage, from your prior health insurer or health plan concerning your creditable coverage under that insurance policy or plan. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

We will give you a creditable coverage certificate when:
(a) Your coverage under the Plan would terminate in the absence of COBRA coverage;
(b) Your coverage under the Plan's COBRA coverage provisions terminates (if you elect coverage under those provisions)
(c) You ask us for a certificate, or someone else does on your behalf, if the request is made at any time while you are covered by the Plan and up to 24 months after coverage ceases.

Requests for a creditable coverage certificate should be sent to **CARE**, Plan Administrator, 4912 Midway Drive, P.O. Box 6130, Temple, Texas 76503-6130. Request must include:
(a) The name of the person for whom the certificate is requested;
(b) The name of the employee, if the person referred to above is a dependent;
(c) The address to which the certificate is to be mailed;

(d) If the request is being made on behalf of another person, evidence of the authority of the person making the request to receive the certificate; and
(e) The requester's signature

Initial Coverage Stage (Part D): The stage where you pay a copayment for your drugs until the total costs paid by you and the Plan have reached the $3,310 limit for the calendar year.

Interpretation: CARE has the authority to construe the Plan and to determine all questions that arise under it. Such power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Plan document. Further, to the extent that any Plan benefit is subject to a determination of medical necessity, reasonableness or the like, **CARE** will make that factual determination. **CARE**'s interpretations and determinations are binding on all employees, retirees, dependents and their beneficiaries.

Medically Necessary: Services or supplies provided by a hospital or covered provider of health care services which the Plan determines:

- are appropriate to diagnose or treat the patient's condition, illness, or injury at the level of care being provided;
- are consistent with standards of good medical practice in the United States;
- are not primarily for the personal comfort of the patient, the family or the provider;
- are not part of or associated with the scholastic education or vocational training of the patient

Medicare Prescription Drug Coverage (Part D): Insurance to help pay for outpatient prescription drugs, vaccines, biological, and some supplies not covered by Medicare Part A or Part B.

Michelle's Law: If continued coverage for a dependent child under an employer-sponsored group health plan is dependent on the child's status as a student and the child is no longer enrolled as a student due to a serious injury or illness, Michelle's Law prohibits that coverage from being terminated for one year after the date on which the child's medically necessary leave of absence begins unless, under the terms of the plan, coverage would otherwise terminate as of an earlier date.

This law will interact with COBRA (if applicable) in the following manner: the 36-month maximum coverage period would begin at the expiration of the one year extension under Michelle's Law. A written certification must be provided by a treating physician of the dependent child to the group health plan in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

Network Pharmacy (Part D): A network pharmacy is a pharmacy where a member of our plan can get their prescription drug benefits. We call them "network" pharmacies because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Preferred Brand Drugs (Part D): A Non-Preferred Brand Drug generally costs more than Generic or Preferred Brand drugs.

Out-of-Pocket Drug Costs (Part D) - Copayment and/or coinsurance paid by you and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare, Medicare's Coverage Gap Discount Program, etc.

Does NOT include payments made for **a)** plan premiums, **b)** drugs not covered by your plan, **c)** non-Part D drugs (such as drugs you receive during a hospital stay), **d)** and drugs obtained at a non-network pharmacy that does not meet out-of-network pharmacy access policy.

Overpayments: CARE will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayment.

Part D: The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D).

Part D Drugs: Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs). Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Brand Drugs (Part D): A preferred brand name is a brand-name drug, which is manufactured by the company that initially developed it. It will generally be at a higher cost than a generic drug, but at a lower cost than a Non-Preferred Brand Drug.

Prior Authorization (Part D): Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Reasonable and Customary: CARE allows benefits, unless otherwise indicated, to the extent that they are reasonable and customary. The reasonable and customary charge for any service or supply is the usual charge for the service or supply in the absence of benefit coverage. The usual charge may not be more than the general level of charges for illness or injury of comparable severity and nature made by other providers within the same geographic area in which the service or supply is provided.

Specialty Drugs (Part D): Specialty Drugs are high-cost drugs that are used to treat complex conditions. These drugs usually require injection and special handling.

Total Drug Costs (Part D) - Drug costs paid by you and the plan.

Women's Health and Cancer Rights of 1998: The Women's Health and Cancer Rights Act of 1998 requires **CARE** to notify you of the coverage required by this act. When the need for such benefits is determined by the patient and the patient's attending physician, the mandate includes the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment for physical complications of all stages of a mastectomy, including lymphedemas (sometimes referred to as swelling associated with the removal of lymph nodes).

Normal deductible, coinsurance, and/or copayment amounts applicable to your health coverage are also applicable to these benefits.

EXCLUSIONS - WHAT THE PLAN DOES NOT COVER

CARE provides benefits only for services and supplies that are Medically Necessary. The Plan reserves the right to determine medical necessity. The fact that a Covered Provider has prescribed, recommended, or approved a service or supply does not, in itself, make it a covered benefit. In **no** event will benefits be payable for:

- Take-home items from an inpatient confinement such as drugs, medical supplies, appliances, medical equipment, personal appliances, or personal comfort items (charges for television, radios, barber services, etc.).
- Any services performed under any other present or future laws enacted by the Congress of the United States or by the legislature of any state including Worker's Compensation.
- Skilled Nursing Facilities, Nursing Homes, Convalescent Homes, Homes for the Aged, Rest Homes or Long Term Care (custodial) nor for any coinsurance amounts for Long Term Acute Care. However, members may receive outpatient physicians' services as provided in these Rules when residing in these institutions.
- For custodial treatment or services, regardless of who recommends them or where they are provided, which could be rendered safely and reasonably by a person not medically skilled and are designed mainly to help the patient with daily living activities (including, but not limited to: personal care, walking, getting in or out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, homemaking such as preparing meals or special diets, acting as a companion or sitter, and/or supervising medication which can usually be self-administered).
- Drugs or experimental procedures NOT APPROVED by the FDA.
- Dental services. **CARE** does NOT provide benefits for services of Dentists or Oral Surgeons, treatment of periodontal, periapical disease, or any condition (other than a cyst or tumor) involving teeth, surrounding tissue or structure, or any expense in connection therewith except for dental services received within twelve (12) months as a result of severe trauma (chewing incidents are NOT considered to be accidental trauma).
- Medical records, filing fees, narratives, reports, or other associated documents.
- Charges by institutions which do not meet the definition of a "Covered Facility."
- Any charge which, in the opinion of **CARE**, is NOT proper.
- Services, equipment or supplies not approved by Medicare (unless otherwise stated in the **CARE** Medicare Secondary Plan Benefit Guide) or for any other exclusion listed or noted in this book.

As provided in the Health Insurance Portability and Accountability Act of 1996, no eligibility requirement of the Plan shall be given any effect to the extent that it discriminates on the basis of a health factor.

INTERNAL GRIEVANCE PROCESS

I. GRIEVANCES: CARE maintains an internal grievance process through which members may seek resolution of grievances other than claims denials or adverse organization determinations. Grievances involving other than claims denials or adverse organization determinations may be resolved only through **CARE**'s internal grievance process. Examples of such grievances include:

- complaints about waiting times, physician demeanor and behavior, or adequacy of health care facilities

- involuntary disenrollment issues

- Quality of Care issues may be resolved through **CARE**'s internal grievance process or by filing a complaint with the QIO* or both.

*Quality Improvement Organization (QIO) is a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare. A QIO is paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think coverage for their hospital stay is ending too soon. You can find the QIO in your state by calling the national (1.800.633.4227) telephone number.

If you have a complaint, we encourage you to first call our **CARE** Customer Service at 1.800.334.1330. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints listed below under **"Procedures**."

II. PROCEDURES (Filing of Grievances*):* If you have a complaint involving other than a claims denial or an adverse organization determination, you may file an oral or a written grievance with the Administrator of **CARE** within 60 days of the event underlying the complaint. The written grievance must include your name, address and a full explanation of your complaint, including specific dates, persons, places and events relevant to your complaint. Please include supporting documentation, if any, when filing your written grievance. To submit an oral grievance, call **CARE** Customer Service at 1.800.334.1330. Mail or deliver your written request to the following address:

INTERNAL GRIEVANCE PROCESS
CARE
4912 Midway Drive
Post Office Box 6130
Temple, Texas 76503-6130

Internal Committee Review
After your oral or written grievance is received, the Administrator will review your grievance for completeness. If the Administrator does not think the grievance is complete, additional information may be requested from you. Once the Administrator deems your grievance complete, your grievance will be referred to an Internal Committee of three (3) to five (5) **CARE** Administrative staff members appointed by the Administrator. The Internal Committee will include among its members at least one **CARE** administrative staff member from the department relevant to your complaint. For example, if your grievance involves an involuntary disenrollment issue, at least one of the Internal Committee members shall be from **CARE**'s Member Services Department. If your grievance involves a complaint about physician demeanor or behavior, at least one of the Internal Committee members shall be from **CARE**'s Credentialing Department.

The Internal Committee will review your complaint and make a decision within 30 days of the receipt of your oral or written grievance unless special circumstances (such as the need for additional information from you and/or other involved parties) require a 14 day extension. If such an extension is necessary, you will be notified and will receive a decision from **CARE** no later than the 14 day extension. If the grievance was oral, the notification of the decision will be oral unless you request the decision in writing. If the grievance was in writing, or you request the oral decision in writing, the decision will set forth in writing the findings and resolution of the complaint. All grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing and the response must include a description of the member's right to file a

written complaint with the QIO.

You have the right to file an expedited grievance if a request for an expedited determination or appeal for service was denied and the regular time frame was applied or we needed extra days (14) to consider your request or appeal for service. An expedited grievance must be decided within 24 hours if our decision to deny or delay puts your life or health at risk. If we determine that we should have expedited your request, we will do so and notify you of our decision.

MEDICARE CLAIM & APPEAL PROCEDURES

Introduction: The terms we, us, and **CARE** are used throughout this Section, but the appeal or decision may not be the type that **CARE** would make as an HCPP. Carefully examine your case, the benefits and the type of request. It will delay your process if you send a decision request to **CARE** that should go to Railroad Medicare, Original Medicare, or a Medicare Intermediary on facility services.

This section gives the rules for making complaints about Medicare services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a **CARE** member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from **CARE** Medicare Plans or penalized in any way if you make a complaint.

Please refer to Original Medicare rules in your current year's Medicare & You book for additional guidance on your appeal rights under Original Medicare. If you do not have a current Medicare & You book, please call Medicare at 1.800.633.4227 to get a copy.

To file a CARE Medicare Secondary Plan payment appeal: You have the right to appeal payment amounts or denied payments by your **CARE** Medicare Secondary Plan. The steps that are available to you are as follows:

- You, your representative or a participating provider must file your appeal in writing within 60 days of the time the claim for Medicare secondary payment was processed by **CARE**. Additional information that may aid in reconsidering the payment must be submitted at the time of your appeal. **CARE** must return a written determination to you within 30 days from the date of receipt of your written appeal.

- Should we uphold our initial payment decision and you do not agree you can next appeal to the **CARE** Board of Directors within 60 days of that decision. The **CARE** Board of Directors has 30 days in which to make a decision on this appeal. Mail your **CARE** payment appeal to: **CARE**, Attn: Corporate Secretary; P.O. Box 6130; Temple, Texas 76503-6130

How to make complaints in different situations: Who to contact for complaints about your Medicare services or payments depends on who processed the claim for your Original Medicare benefits. As a member of the **CARE** Medicare Plans, you continue to access your benefits through Original Medicare whether or not the provider is participating with **CARE**. Being a member of the **CARE** Medicare Plans includes continued benefit coverage from Original Medicare.

- **CARE** HCPP can only perform your Medicare appeal if we processed the original Part B claim from a **CARE** participating HCPP provider.

- All of your appeals for Medicare Part B claims that were originally processed by Railroad Medicare (Palmetto GBA) must go directly to them and not **CARE**. For more information on how to file an Original Medicare appeal, please refer to your current Medicare & You book.

• All of your appeals for Medicare Part A benefits are made to the Original Medicare intermediary that processed your claim. **CARE** does not process your Medicare Part A services. However, **CARE** does pay secondary to Medicare for your Part A benefits unless listed as an exclusion on page 14.

CARE HCPP participating physicians can send your claims to either **CARE** or Railroad Medicare (Palmetto GBA) because you are still using your Original Medicare benefits. If a **CARE** participating physician sends your claims to Railroad Medicare, we cannot perform a Medicare appeal for you. Your appeal must go to Railroad Medicare.

Railroad Medicare must pay all of your Medicare Part B claims for services from other than HCPP providers that do not participate with **CARE**. As a **CARE** Medicare member, you may choose to get care from nonparticipating HCPP providers anywhere *(except for Topeka Medicare members, refer to page 4*), and at any time using your Original Medicare benefits.

When **CARE** HCPP participating physicians send your claims to Railroad Medicare (Palmetto GBA), we cannot automatically pay your **CARE** Medicare Secondary Plan benefits; either you or the physician must send the Medicare Summary Notice (MSN) and a copy of the claim to **CARE** to receive your payment. This section tells you how to complain about services or payment in each of the following situations:

- Part 1. Complaints about what benefit or service we will provide you or what we will pay for/cover.
- Part 2. Complaints if you think you are being discharged from the hospital too soon.
- Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For more information about grievances, including how to file a grievance, see page 14.

Complaints about what benefit or service CARE HCPP, Railroad Medicare, or Original Medicare will provide you or what they will pay for.

What Are Complaints About Your Services Or Payment For Your Care?: If you are not getting the care you want, and you believe that Medicare covers this care.

• If you are told that Medicare does not cover the medical treatment your doctor or other medical provider wants to give, and you believe that Medicare covers this treatment.
• If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
• If you have received care that you believe Medicare should cover, but we have refused to pay for this care because we say it is not covered.

What Is An Organization Determination?: An organization determination is the initial decision about whether Medicare will provide the medical care or service you request, or pay for a service you have already received. If the initial decision is to deny your request, you can appeal the decision by going on to Appeal Level 1 (see below). You may also appeal if Medicare or **CARE** has failed to make a timely initial decision on your request. When an initial decision is made, it is the interpretation of how the benefits and services that are covered by Original Medicare apply to your specific situation.

This **CARE** Medicare Secondary Plan Benefit Guide and your current Medicare & You book, and any amendments you may receive describe the benefits and services covered by Medicare and **CARE**, including any limitations that may apply to these services. This booklet also lists exclusions (services that are not covered by Original Medicare and/or **CARE**).

Who May Ask For An Initial Decision About Your Medical Care or Payment? Depending on the situation, you can ask for an initial decision yourself, or you can name someone to do it for you. This person you name would be your authorized representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at **CARE**, P.O. Box 6130, Temple, Texas 76503-6130. You can call us at 1.800.334.1330, TTY use the national number 711, to learn how to name your authorized representative. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Do You Have A Request For Medical Care That Needs To Be Decided More Quickly Than A Standard Time Frame? A decision about whether Medicare covers medical care can be a standard decision that is made within the standard time frame (typically within 14 days; see below), or it can be a fast decision that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called an expedited organization determination.

You can ask for a fast decision only if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking For a Standard Decision: To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail request in writing to the following address: **CARE**, P. O. Box 6130, Temple, Texas 76503-6130. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

Asking For a Fast Decision: You, any doctor, or your authorized representative can ask for a fast decision (rather than a standard decision) about medical care by calling us at 1.800.334.1330 (for TTY, call the national number 711). Or, you can deliver a written request to **CARE** at 4912 Midway Drive, Temple, Texas 76502. You can send a written request to **CARE**, PO Box 6130, Temple, Texas 76503-6130, or fax it to 254.774.7652. Be sure to ask for a fast or 72-hour review. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

- If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

- If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a fast decision, we will automatically give you a fast decision. The letter will also tell you how to file a grievance if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a fast grievance. If we deny your request for a fast initial decision, we will give you a standard decision.

What Happens Next When You Request An Initial Decision? If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

1. For a decision about payment for care you already received.

• We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can appeal (also called reconsideration) this decision.

2. For a standard initial decision about medical care.

• We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). If we take additional days, we will notify you in writing. If you feel that we should not take additional days, you can make a specific type of complaint called a *grievance*. Page 14 of this booklet tells how to file a grievance. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

• We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

• If you have not received an answer from us within 14 days of your request, or by the end of an extended time period, you have the right to appeal.

3. For a fast decision about medical care.

• If you receive a fast decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it — sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you file a fast *grievance*. Page 14 of this booklet tells how to file a grievance.

• We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

Appeal Level 1: If **CARE** HCPP or the Original Medicare claims processor denies your request for coverage or payment of a service, you may ask us (or them) to reconsider the decision. This is called an appeal or request for reconsideration. Please call us at 1.800.334.1330 if you need help in filing your appeal. We give your request to different people than those who were involved in making the initial decision. This helps ensure that we give your request a fresh look. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

If your appeal concerns a decision we, or Original Medicare made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a *fast* appeal. The procedures for deciding on a *standard* or a *fast appeal* are the same as those described for a standard or fast *initial decision*.

Getting Information To Support Your Appeal. We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You

have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

If the decision is one that would be made by **CARE**, you can give us your additional information in any of the following ways:

- In writing, to **CARE**, P. O. Box 6130, Temple, Texas 76503-6130.
- By fax, at 254.774.7652.
- By telephone — if it is a fast appeal — at 1.800.334.1330.
- In person, at **CARE**, 4912 Midway Drive, Temple, Texas 76502

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at the above address. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How Do You File Your Appeal Of The Initial Decision? The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the rules under "Who may ask for an *initial decision* about medical care or payment?" If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How Soon Must You File Your Appeal? You need to file your appeal within 60 days after you are notified of the initial decision. You will be given more time if you have a good reason for missing the deadline. To file your appeal you can call us at 1.800.334.1330 or send the appeal to us in writing at the above address. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

You may also send your appeal to the Railroad Retirement office. Please note that sending your appeal to that office instead of to us will cause a delay when we begin the appeal, since that office must forward your appeal request to us.

What if you want a "fast" appeal? The rules about asking for a fast appeal are the same as the rules about asking for a fast decision. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

How soon must we decide on your appeal? How quickly the decision is made on your appeal depends on the type of appeal. Remember, **CARE** can only perform an appeal on a Medicare claim that was processed by us. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

1. For a decision about payment for care you already received.
   - After your appeal is received, a decision must be made within 60 days. If the decision is not made within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.
   - Remember, this must be medical care you want to receive from a **CARE** participating physician. After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

‣ Remember, this must be medical care you want to receive from **CARE** participating physician. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227. After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if there is some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2

What Happens Next If We Decide Completely In Your Favor?

1. For a decision about payment for care you already received.

‣ We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

2. For a standard decision about medical care.

‣ We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care no later than upon the expiration of the date of the extension. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

3. For a fast decision about medical care.

‣ We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your care no later than upon the expiration date of the extension. If the decision is not one that would be made by **CARE**, we will direct you to the proper resource or you can call Medicare at 1.800.633.4227.

What Happens Next If We Deny Your Appeal? If we deny any part of your appeal in Step 2, then your appeal automatically goes on to Appeal Level 2 where an independent organization will review your case. This independent review organization contracts with the Federal government and is not part of **CARE** or Original Medicare. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. For a decision about payment for care you already received.

- We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your Level 1 appeal.

2. For a standard decision about medical care.

- We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a fast decision about medical care.

- We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If **CARE** HCPP, or the Original Medicare claims processor denies any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization.

What Independent Review Organization Does This Review? In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with Centers for Medicare and Medicaid

Services (CMS), the government agency that runs the Medicare program. This organization has no connection to us. We, or the involved Original Medicare claims processor will tell you when your appeal is sent to this organization. You have the right to get a copy of your case file that is sent to this organization.

How Soon Must The Independent Review Organization Decide? After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For an appeal about payment for care, the independent review organization has up to 60 days to make a decision.

2. For a standard appeal about medical care, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the Independent Review Organization Decides Completely In Your Favor. The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For an appeal about payment for care, **CARE** or the responsible Original Medicare claims processor must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care, **CARE** or Original Medicare must authorize the care you have asked for within 72 hours after receiving notice of the decision, or provide the care no later than 14 days after receiving the decision.

3. For a fast appeal about medical care, **CARE**, or Original Medicare must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case at appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical claim does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

How Soon Does the Judge Make A Decision? The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If The Judge Decides In Your Favor: CARE or Original Medicare must pay for, authorize, or provide the service you have asked for within 60 days from the date the decision notice is received. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If The Judge Rules Against You: You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review**.**

Appeal Level 4: Your case may be reviewed by a Medicare Appeals Council.

This Council Will First Decide Whether To Review Your Case: The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you, **CARE** or Original Medicare may request a review by a Federal Court Judge. The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How Soon Will The Council Make A Decision? If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If The Council Decides In Your Favor: **CARE** or Original Medicare must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If The Council Decides Against You: If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you, **CARE** or Original Medicare have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court: In order to request judicial review of your case, you must file a civil action in a United States District Court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you, **CARE** or Original Medicare may ask a Federal Court Judge to review the case.

How Soon Will The Judge Make A Decision? The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

ADVANCE DIRECTIVES

All adult individuals in hospitals, nursing homes, and other health care settings have certain rights. For example, you have a right to confidentiality of your personal and medical records and to know what treatment you will receive.

You also have another right. You have the right to fill out a paper, known as an "advance directive." The paper says in advance what kind of treatment you want or do not want under special serious medical conditions - conditions that would prevent you from telling your doctor how you want to be treated. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know your specific wishes about decisions affecting your treatment?

This article answers some questions related to a federal law which took effect December 1, 1991 that requires most hospitals, nursing facilities, hospices, home healthcare programs and health maintenance organizations

to give you information about advance directives and your legal choices in making decisions about medical care. The law is intended to increase your control over medical treatment decisions. The information in this article can help you make decisions in advance of treatment. Because this is an important matter, however, you may wish to talk to family, close friends, and your doctor before deciding whether you want an advance directive.

Finally, it is important to remember that state laws differ about the legal choices available to individuals for treatment options that can be honored by hospitals and other health care procedures and organizations.

What Is An Advance Directive? Generally, an advance directive is a written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directive are:

- a "Living Will"; and
- a "Durable Power of Attorney for Health Care."

An advance directive allows you to state your choices or health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive can enable you to make decisions about your future medical treatment. You can say "yes" to treatment you want, or say "no" to treatment you don't want.

What Is A Living Will? A Living Will generally states the kind of medical care you want (or do not want) if you become unable to make your own decision. It is called a "living will" because it takes effect while you are still living. Most states have their own living will forms, each somewhat different. It may also be possible to complete and sign a preprinted living will form available in your own community, draw up your own form, or simply write a statement of your preferences or treatment. You may also wish to speak to an attorney or your physician to be certain you have completed the living will in a way that your wishes will be understood and followed.

What Is Durable Power Of Attorney For Health Care? In many states, a "Durable Power of Attorney for Health Care" is a signed, dated and witnessed paper naming another person, such as a husband, wife, daughter, son or a close friend, as your "agent" or "proxy" to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want to wish to avoid. Some states have laws that require that specific, approved forms be used for advance directives. Check your state laws, or ask your physician or attorney.

Which Is Better: A Living Will OR A Durable Power Of Attorney For Health Care? In some states, laws make it better to have one or the other. It may also be possible to have both or to combine them in a single document that describes treatment choices in a variety of situations (ask your doctor about these) and names someone (called your "agent" or "proxy") to make decisions for you, should you be unable to make decisions for yourself.

Can I Change My Mind After I Write A Living Will Or Health Care Power Of Attorney? Yes. You may change or cancel these documents at any time in accordance with state law. Any change or cancellation should be written, signed and dated in accordance with state law, and copies should be given to your doctor, or to others to whom you may have given copies of the original. In addition, some states allow you to change an advance directive by oral statement. If you wish to cancel an advance directive while you are in the hospital, you should notify your doctor, your family, and others who may need to know. Even without a change in writing, your wishes stated in person directly to your doctor generally carries more weight than a living will or a durable power of attorney, as long as you can decide for yourself and can communicate your wishes. But be sure to state your wishes clearly and be sure that they are understood.

What If I Fill Out An Advance Directive In One State And Am Hospitalized In A Different State? The law on honoring an advance directive from another state is unclear. Because an advance directive tells your wishes regarding medical care, it may be honored wherever you are, if it is made known. But if you spend a great deal of time in more than one state, you may wish to consider having your advance directive meet the laws of both states, as much as possible.

What Should I Do With My Advance Directive If I Choose To Have One?: Make sure that someone, such as your lawyer or family member, knows that you have an advance directive and knows where it is located. You might also consider the following:

- If you have a durable power of attorney, give a copy of the original to your "agent" or "proxy."
- Ask your physician to make your advance directive part of your permanent medical record.
- Keep a second copy of your advance directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet, which states that you have an advance directive and where it is located and who your "agent" or "proxy" is, if you have named one.

This article is provided for your information and convenience. It is not intended to replace medical or legal advice. If you have questions about these matters, you should consult your physician or your attorney.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a member / participant of **CARE**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Employee Retirement Income Security Act provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the cooperation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Administrator may charge a reasonable fee for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduce or Eliminate Pre-existing Condition Limitation Periods: You have the right to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants, the Employee Retirement Income Security Act imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you, and the other participants and beneficiaries. No one, including your employer, union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under the Employee Retirement Income Security Act.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

The Directors are charged with the proper application of the Rules and Benefits of **CARE** as provided in Public Law 93-406, the Employee Retirement Income Security Act. Should you have any questions or need additional copies of the **CARE** Medicare Secondary Plan Benefit Guide, you may write: **CARE**, Plan Administrator; 4912 Midway Drive; P. O. Box 6130; Temple, Texas 76503-6130.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Employee Benefits Security Administration.

SUBROGATION AND REIMBURSEMENT

Benefits Subject To This Provision: This provision shall apply to all benefits provided under any section of the **CARE** Plan. Any payments a Member is required to make under this Section shall be made to the Plan's office in Bell County, Texas.

Statement of Purpose: *Subrogation* and *reimbursement* represent significant **CARE** Plan assets and are vital to the financial stability of the Plan. *Subrogation* and *reimbursement* recoveries are used to pay future claims by other **CARE** members. Anyone in possession of these assets holds them as a fiduciary and

constructive trustee for the benefit of **CARE**. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets.

Definitions

Another Party: "*Another party*" shall mean any individual or entity, other than **CARE**, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered member's* injuries or illness. "*Another party*" shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a *covered member's* own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer; governmental entity or any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Member: A "*Covered Member*" shall mean any employee or former employee who is duly enrolled for coverage under the **CARE** Plan as well as any duly enrolled dependent of such an individual.

Solely for purposes of determining an individual's rights and obligations under this Subrogation and Reimbursement provision, a "*Covered Member*" shall also include but not be limited to any beneficiary, dependent, spouse or legal or personal representative of an individual described in the preceding paragraph, including parents, guardians, attorneys, trustees, administrators or executors of an estate of such an individual and the heirs of such an individual's estate.

Recovery: "*Recovery*" shall mean any and all monies identified or paid to the *covered member* through or from *another party* by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A *recovery* exists as soon as any fund is identified as compensation for a *covered member* from *another party*. Any *recovery* shall be deemed to apply, first, for *reimbursement* of **CARE**'s lien.

Subrogation: "*Subrogation*" shall mean **CARE**'s right to pursue the *covered member's* claims for medical or other charges paid by the Plan against *another party*.

Reimbursement: "*Reimbursement*" shall mean repayment to **CARE** of recovered medical or other benefits that it has paid toward care and treatment of the injury or illness for which there has been a *recovery*.

Plan Administrator Discretion: The Plan Administrator has maximum discretion to interpret the terms of this provision.

When This Provision Applies: A *covered member* may incur medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the *covered member* or another person; or *another party* may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the *covered member* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the **CARE** Plan will be secondary, not primary, and the *covered member* agrees, as a condition of receiving benefits from **CARE**, to transfer to **CARE** all rights to recover damages in full for such benefits.

Duties Of The Covered Member: When a right of recovery exists, and as a condition to any payment by **CARE** (including payment of future benefits for other illnesses or injuries), the *covered member* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by **CARE** as well as doing and providing whatever else is needed, to secure **CARE**'s rights of

subrogation and *reimbursement*, before any medical or other benefits will be paid by **CARE** for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in **CARE**'s best interests to pay medical or other benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, **CARE** still will be entitled to *subrogation* and *reimbursement*. In addition, the *covered member* will do nothing to prejudice **CARE**'s right to *subrogation* and *reimbursement* and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A *covered member* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the *recovery* subject to the Plan's lien to **CARE** under the terms of this provision. A *covered member* who receives any such *recovery* and does not immediately tender the *recovery* to **CARE** will be deemed to hold the *recovery* in constructive trust for **CARE**, because the *covered member* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until **CARE** has been fully reimbursed.

The *covered member* must: Execute and deliver a subrogation and reimbursement agreement, if requested by the Plan Administrator; Authorize **CARE** to sue, compromise and settle in the *covered member's* name to the extent of the amount of medical or other benefits paid for the injuries or illness under the **CARE** Plan and the expenses incurred by **CARE** in collecting this amount, and assign to **CARE** the *covered member's* rights to *recovery* when this provision applies; Include the benefits paid by **CARE** as a part of the damages sought against another party; Immediately reimburse **CARE**, out of any recovery made from another party, the amount of medical or other benefits paid for the injuries or illness by **CARE** up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise; Notify **CARE** in writing of any proposed settlement and obtain **CARE**'s written consent before signing any release or agreeing to any settlement; and Cooperate fully with **CARE** in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by **CARE**.

First Priority Right of Subrogation and/or Reimbursement: Any amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by **CARE** in collecting this amount. The Plan will be subrogated to all rights the covered member may have against that other person or another party and will be entitled to first priority reimbursement out of any recovery to the extent of the Plan's payments. In addition, **CARE** shall have the first priority lien against any recovery to the extent of benefits paid and to be payable in the future. **CARE**'s first priority lien supersedes any right that the covered member may have to be "made whole." In other words, **CARE** is entitled to the right of first reimbursement out of any recovery the covered member procures or may be entitled to procure regardless of whether the covered member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs; and regardless of whether or not the recovery is designated as payment for medical expenses or otherwise. Additionally, **CARE**'s right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of recovery as pain and suffering or otherwise. As a condition to receiving benefits under the Plan, the covered member agrees that acceptance of benefits is constructive notice of this provision.

When a Covered Member Retains an Attorney: If the covered member retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the covered member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against **CARE** in his pursuit of recovery. The Plan will not pay the covered member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the covered member's attorneys' fees and costs. An attorney who receives any recovery

(whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to **CARE** under the terms of this provision. As a possessor of a portion of the recovery, the covered member's attorney holds the recovery as a constructive trustee and fiduciary and is obligated to tender the recovery immediately over to the Plan. A covered member's attorney who receives any such recovery and does not immediately tender the recovery to **CARE** will be deemed to hold the recovery in constructive trust for **CARE**, because neither the covered member nor his attorney is the rightful owner of the portion of the recovery subject to **CARE**'s lien.

When The Covered Member Is a Minor Or Is Deceased Or Incapacitated: The provisions of this subrogation and reimbursement provision apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor *covered member* and to the heirs or personal and legal representatives of the estate of a deceased or incapacitated *covered member*, regardless of applicable law and whether or not the representatives have access or control of the *recovery*. No representative of a *covered member* listed here may allow proceeds from a *recovery* to be allocated in a way that reduces or minimizes the **CARE** claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment; or releasing any claim in whole or in part without full compensation therefore.

When a Covered Member Does Not Comply: When a covered member does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered member and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the **CARE** Plan by the amount due as a dollar for dollar satisfaction for the reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by **CARE**. The reductions will equal the amount of the required reimbursement. If **CARE** must bring an action against a covered member to enforce the provisions of this section, then that covered member agrees to pay **CARE**'s attorneys' fees and costs, regardless of the action's outcome.

Recovery of Future Benefits: In certain circumstances, a covered member may receive a recovery that exceeds the amount of **CARE**'s payments for past and/or present expenses for treatment of the illness or injury that is the subject of the recovery. In other situations, a covered member may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the illness or injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not cover any present or future expenses related to the illness or injury for which compensation was provided through a current or previous recovery. The covered member is required to submit full and complete documentation of any such recovery in order for **CARE** to consider eligible expenses that exceed the recovery. To the extent a covered member's recovery exceeds the amount of the **CARE** lien; the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the illness or injury. In those situations following any recovery that exceeds the amount of **CARE**'s lien, the covered member will be solely responsible for payment of medical bills related to the illness or injury out of the remaining recovery. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan Administrator has sole discretion to determine whether expenses are related to the illness or injury to the extent this provision applies. Acceptance of benefits under the **CARE** Plan for an illness or injury which the covered member has already received a recovery may be considered fraud, and the covered member will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate, including denial of present or future benefits under the Plan.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: October 1, 2015

CARE, the "Plan" is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1: Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures - Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations:

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan has amended its plan documents to protect your PHI as required by federal law.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may not and does not use your genetic information that is PHI for underwriting purposes.

Uses and disclosures that require your written authorization:

(1) Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

(2) Your written authorization generally will be obtained for any use or disclosure of PHI for marketing, which means a communication to encourage you to purchase or use a product or service. Marketing does not include communications about refill reminders or drugs you currently use, case management or care coordination, descriptions about your plan of benefits and related information, and information about treatment alternatives.

(3) Your written authorization would be required for any sale of PHI.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization or opportunity to object is not required:

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(4) The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization. Your authorization may be revoked in writing at any time, except to the extent that the Plan has relied upon it or as otherwise provided in the federal privacy rules.

Section 2: Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures, and Receive Alternative Communications - You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

Right to Inspect and Copy PHI - You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. Information will be provided in the form and format you request, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by you and the Plan.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days of receipt of the request. A single 30-day extension in writing is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI - You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures - At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request - To obtain a paper copy of this Notice contact the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330. This right applies even if you have agreed to receive the Notice electronically.

A Note About Personal Representatives - You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

The Plan is required by law to maintain the privacy of PHI, to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. In addition, the Plan may not and does not use your genetic information that is PHI for underwriting purposes.

This notice is effective beginning October 1, 2014 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Plan still maintains PHI. If we make material changes to our privacy practices, copies of revised notices will be mailed to all members then covered by the Group Health Plan. Copies of our current notice may be obtained by contacting **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice, in accordance with federal distribution rules. The notice and any revisions will also be posted on our Web site at www.carehealthplan.com.

Minimum Necessary Standard - When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:
- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services; uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330, debbiem@care.vvm.com.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Filing instructions are available at:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.

The Plan will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: **CARE**, Attn: Privacy Office, 4912 Midway Drive, Temple, Texas 76502, Telephone: 254.773.1330, debbiem@care.vvm.com.

Conclusion - PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

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LEGAL PROCEEDINGS AND CHOICE OF CONTROLLING LAW: ALL LAWSUITS BROUGHT BY CARE OR BY ANY MEMBER ARISING OUT OF OR CONSTRUE THIS PLAN SHALL BE BROUGHT ONLY IN BELL COUNTY, TEXAS OR IN THE WACO DIVISION OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS AND THE LAW OF THE STATE OF TEXAS TO THE EXTENT NOT OTHERWISE PREEMPTED BY ERISA.

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CARE DISENROLLMENT FORM

If you wish to discontinue your membership with **CARE**,
COMPLETE AND RETURN this form to:

CARE
P. O. Box 6130
Temple, Texas 76503-6130
Attn: Member Services Department

I, _____, wish to discontinue my membership
(name of member)

with **CARE** effective the first day of _____, _____.
(month) (year)

I understand that by discontinuing my membership with **CARE**, I am also disenrolling from your Health Care Prepayment Plan (HCPP).

_____
Medicare Number

_____ _____
(signature) (date)

This form is for disenrollment in **CARE**. Your Medicare coverage is intact. If you would like assistance in obtaining other health care insurance, you may contact your State Health Insurance Assistance Program, State Insurance Department and State Medical Assistance Office.

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NOTES

CARE RAILROAD HEALTHCARE
4912 Midway Drive - P.O. Box 6130
Temple, TX 76503-6130

RETURN SERVICE REQUESTED