MedCare Partners
Health Plan of Texas



Enrollment Book **2027**

OUR 2027 MEDICARE ADVANTAGE PLANS
MedCare Classic (HMO) - H5767-001
MedCare Focus (HMO C-SNP) - H5767-002
MedCare Choice (HMO C-SNP) - H5767-003
HARRIS COUNTY, TEXAS

MedCare Partners
Health Plan of Texas

2027 SUMMARY of BENEFITS

MedCare Classic (HMO) H5767-001

Harris County, Texas

Benefits effective January 1, 2027 – December 31, 2027

MedCare Classic (HMO)
H5767-001
January 1, 2027 - December 31, 2027

MedCare Partners Health Plan of Texas is an HMO with a Medicare contract. Enrollment in MedCare Partners Health Plan of Texas depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-833-MCP TX01 (1-833-627-8901 (TTY 711) and request the "Evidence of Coverage" or access it online at www.mcpartnerstx.com.

To join **MedCare Classic (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following county in Texas: Harris.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7-days a week, 24-hours a day. TTY users should call 1-877-486-2048.

This document is available in other languages such as Spanish and Vietnamese, and in other formats such as Braille, large print or audio.

For more information, please call us at 1-833-MCPTX01(1-833-627-8901 (TTY users should call 711) 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31 (except Thanksgiving and Christmas Day) and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30 (except for federal holidays). Messages received on holidays and outside of our business hours will be returned within one business day. You may also visit us at www.mcpartnerstx.com.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Monthly Plan Premium *(includes both medical and drugs)*	You pay $0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible.
Maximum out-of-pocket responsibility *(Does not include prescription drug costs)*	You pay no more than $1,500 annually for in-network Medicare-covered benefits.
Inpatient Hospital	$200 copay per day for days 1 - 4. $0 copay per day for days 5 - 90. Services may require prior authorization and/or a referral.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Outpatient Hospital • Outpatient services • Observation services	$150 copay per outpatient hospital visit $0 copay per observation stay Services may require prior authorization and/or a referral.
Ambulatory Surgery Center (ASC)	$100 copay Services may require prior authorization and/or a referral.
Doctor visits • Primary care providers • Specialists	• $0 copay per visit • $15 copay per visit Specialist services may require prior authorization and/or a referral.
Preventive care *Including but not limited to:* • Vaccinations (flu shots, pneumococcal, COVID, etc.) • Cancer screenings • Glaucoma screening • Diabetes screenings • Annual wellness visit • Diabetes self-management training	$0 copay for all Medicare-covered preventive services
Emergency Care • Emergency services • Worldwide emergency coverage	$150 copay per visit $0 copay for up to $10,000 in worldwide emergency coverage
Urgently needed services	$0 copay per visit

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Diagnostic Services/Labs/ Imaging	For Medicare-covered services, you pay the amounts below. If you receive multiple services on the same day, only the maximum copay applies.
• Diagnostic tests & procedures	• $200 copay
• Lab services	• $0 copay
• MRI, CAT Scan	• $200 copay
• X-Rays	• $0 copay
	Diagnostic procedures, tests, and lab services may require prior authorization and/or a referral.
Hearing Services	
• Medicare-covered benefits	• $0 copay
• Routine hearing exam	• $0 copay for up to one exam per year
• Hearing aid fittings and evaluations	• $0 copay for unlimited hearing aid evaluations/fittings
• Hearing aids (all types)	• $149 copay per TruHearing Advanced hearing aid for up to one hearing aid per ear every three years
Dental services	You receive a **$2,000 benefit allowance** every year for preventive and comprehensive dental benefits combined.
Medicare-covered services	• $0 copay
Preventive Dental	• $0 copay for preventive services
• Oral exams, cleanings, fluoride treatments, x-rays, and other diagnostic services	
Comprehensive Dental	
• Restorative services	• 20% - 50% of the cost
• Endodontic services	• 20% of the cost
• Periodontic services	• 20% of the cost
• Prosthodontics services	• 50% of the cost
• Maxillofacial Prosthetics	• 20% of the cost
• Oral and Maxillofacial Surgery	• 20% of the cost
	Comprehensive dental services require prior authorization and/or a referral.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Vision services • Medicare-covered benefits • Routine Eye Exam • Routine eyewear (eyeglass lenses, eyeglass frames, and contact lenses)	• $0 copay, including one pair of Medicare-covered eyewear after cataract surgery • $0 copay for unlimited routine eye exams every year • $200 allowance for eyeglass frames and contact lenses (in lieu of eyeglass frames) every year. • Eyeglass lenses are unlimited and include single vision, lined trifocal, lenticular and standard progressives. Any costs above the annual allowance is the member's responsibility.
Mental Health Services • Inpatient psychiatric services • Mental health specialty services, including psychiatric services ○ Individual sessions ○ Group sessions	• $200 copay per day for days 1 – 4 $0 copay for days 5 – 90 $0 for days 1 – 60 lifetime reserve days Up to 190 days of inpatient psychiatric care for lifetime. • $15 copay for individual sessions • $0 copay for group sessions Services may require prior authorization and/or a referral.
Skilled Nursing Facility	$0 copay for days 1 – 20 $221 copay per day for days 21 – 100 100% of all costs for each day after day 100 of the benefit period. Services may require prior authorization and/or a referral.
Outpatient Rehabilitation • Physical therapy • Occupational therapy • Speech therapy	$0 copay Services may require prior authorization and/or a referral.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Ambulance • Ground ambulance • Air ambulance	• $0 copay for non-emergency transports • $200 copay for all other ground transports • 20% of the cost Non-emergency transport services may require prior authorization.
Transportation (routine)	$0 copay for up to 36 one-way trips to plan-approved health-related locations
Medicare Part B drugs • Insulin • Chemotherapy & other drugs	0% - 20% of the cost for Part B drugs $30.00 copay for a 30-day supply of Part B insulins 0% - 20% of the cost for other Part B drugs, including chemotherapy
Medical Equipment & Supplies • Durable medical equipment (DME) • Prosthetics • Diabetic therapeutic shoes or inserts • Diabetic monitors	20% of the cost for all DME, prosthetics, and diabetic shoes/inserts, supplies and monitors DME and prosthetics services may require prior authorization.
Chiropractic • Medicare-covered services • Routine chiropractic services	• $0 copay for Medicare-covered services • $0 copay for routine chiropractic services. See Combined Benefit Package for Chiropractic & Acupuncture below.
Acupuncture • Medicare-covered services • Routine acupuncture services	• $0 copay for Medicare-covered services • $0 copay for routine acupuncture services. See Combined Benefit Package for Chiropractic & Acupuncture below.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Combined Benefit Package: Chiropractic & Acupuncture	$0 copay for up to 30 total visits per year that can be used for either routine chiropractic services or routine acupuncture services.
Outpatient Substance Abuse • Individual sessions • Group sessions	 • $15 copay per session • $0 copay per session Services may require prior authorization and/or a referral.
Renal Dialysis	20% of the cost
Podiatry • Medicare-covered • Routine podiatry	 $0 copay $0 copay for up to 6 routine foot care visits per year Services may require prior authorization and/or a referral.
Annual Physical Exam	$0 copay for a routine annual physical exam Services may require prior authorization. There may be costs associated with any diagnostic radiology services performed with the annual exam.
Flex Card	You pay $0 for a **$265 quarterly** combined allowance to use for any of the following: • Over-the-Counter (OTC) items • Routine Chiropractic Care • Routine Acupuncture Treatments • Therapeutic Massage • Comprehensive dental services • Vision eyewear • Prescription Hearing Aids (all types)
Meals	$0 copay for up to 3 meals per day for up to 7 calendar days after each inpatient facility discharge.
Fitness	$0 copay for up to $25 per month reimbursement on a gym membership or fitness classes.

Premiums and Benefits	MedCare Classic (HMO) (H5767-001)
Home & Bathroom Safety Devices & Modifications	$0 copay for a shower chair.
Personal Emergency Response System (PERS)	$0 copay for the PERS benefit to receive emergency alert services from ADT Security Services (ADT). Members will have access to a customizable PERS offering, including three (3) emergency alert solutions: • Medical Alert Basic (PERS Basic): an in-home unit with range of up to 300-feet • Medical Alert Plus (PERS Plus): an in-home unit with 600-foot pendant range • On-The-Go (PERS On-The-Go): Mobile base unit with optional Fall Detection All solutions feature: • Two-way voice communication to ADT monitoring center • Water resistant pendants or wristbands • 24/7/365 monitoring service • The optional Fall Detection system pairs with the Medical Alert Plus and On-The-Go solutions and enables members to send an alert to ADT's customer monitoring center automatically when a fall is detected, even if the button is not pressed as well as when the help button is pressed.
Nursing Hotline	$0 copay for 24 hours a day/7 day a week access to a nursing hotline for health-related questions or concerns.

Part D Prescription Drugs			
Part D Deductible	$0		
Initial Coverage	In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach **$2,400**.		
	Standard Retail cost sharing (30-day supply)	**Standard Retail cost sharing (90-day supply)**	**Mail Order cost sharing (90-day supply)**
Tier 1 - Preferred Generic (including insulins)	$0 copay	$0 copay	$0 copay
Tier 2 – Generic Insulins	$3 copay $3 copay or 25% of the cost	$9 copay $9 copay or 25% of the cost	$6 copay $6 copay or 25% of the cost
Tier 3 - Preferred Brand Insulins	$35 copay $35 copay or 25% of the cost	$105 copay $105 copay or 25% of the cost	$70 copay $70 copay or 25% of the cost
Tier 4 - Non-Preferred Drug Insulins	$100 copay $35 copay or 25% of the cost	$300 copay $105 copay or 25% of the cost	$200 copay $70 copay or 25% of the cost
Tier 5 - Specialty Tier Insulins	33% of the cost $35 copay or 25% of the cost	Long-term supply not available	Long-term supply not available
Tier 6 - Select Care Drugs (including insulins)	$0 copay	$0 copay	$0 copay
Catastrophic Coverage *(after you or others on your behalf pay $2,400)*	In this stage, you pay nothing for your covered Part D drugs and drugs offered under our enhanced drug benefit. You generally stay in this stage for the rest of the calendar year.		
Cost sharing may change depending on point-of-service (mail-order, retail, LTC, home infusion), the pharmacy you choose and when you enter a new phase of the drug stages.			
Important message about what you pay for insulin	At a retail pharmacy, you won't pay more than 25% of the cost or $35 for a one-month supply of each insulin product covered by our plan (whichever is less).		
Important message about what you pay for vaccines	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.		
Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1.800.772.1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1.800.325.0778.			

Additional Details and Contact Information

Who can join?	**You must:** • have both Medicare Part A and Part B • live in the plan service area (Harris County Texas) • be a United States citizen or be lawfully present in the United States
Member Services Phone Number	**+1-866-MCPTX01 +1(866) 627-8901**
TTY	**711**
Hours of Operation	**October 1 to March 31:** 8 am to 8 pm, 7 days a week (except Thanksgiving and Christmas Day) **April 1 to September 30:** 8 am to 8 pm, Monday through Friday (except for federal holidays) Messages received on holidays and outside of our business hours will be returned within one business day.
Website	www.mcpartnerstx.com

MedCare Partners
Health Plan of Texas

2027 SUMMARY of BENEFITS

MedCare Focus (HMO C-SNP) H5767-002

Harris County, Texas

Benefits effective January 1, 2027 – December 31, 2027

MedCare Focus (HMO C-SNP)
H5767-002
January 1, 2027 - December 31, 2027

MedCare Partners Health Plan of Texas is an HMO C-SNP with a Medicare contract. Enrollment in MedCare Partners Health Plan of Texas depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call +1-866-MCPTX01 +1 (866) 627-8901 (TTY 711) and request the "Evidence of Coverage" or access it online at www.mcpartnerstx.com.
To join **MedCare Focus (HMO C-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and be diagnosed with one of the following: diabetes mellitus, chronic heart failure, or cardiovascular disorders. Our service area includes the following county in Texas: Harris.

Except in emergency situations, if you use the providers that are not in our network, we may not for pay these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other languages such as Spanish and Vietnamese, and in other formats such as Braille, large print or audio.

For more information, please call us at +1-866-MCPTX01 +1 (866) 627-8901(TTY users should call 711) 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31 (except Thanksgiving and Christmas Day) and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30 (except for federal holidays). Messages received on holidays and outside of our business hours will be returned within one business day. You may also visit us at www.mcpartnerstx.com.

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
Monthly Plan Premium *(includes both medical and drugs)*	You pay $0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible.
Maximum out-of-pocket responsibility *(Does not include prescription drug costs)*	You pay no more than $900 annually for in-network Medicare-covered benefits.
Inpatient Hospital	$200 copay per day for days 1 - 4. $0 copay per day for days 5 - 90.

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
	Services may require prior authorization and/or a referral.
Outpatient Hospital • Outpatient services • Observation services	$150 copay per outpatient hospital visit $0 copay per observation stay Services may require prior authorization and/or a referral.
Ambulatory Surgery Center (ASC)	$100 copay Services may require prior authorization and/or a referral.
Doctor visits • Primary care providers • Specialists	• $0 copay per visit • $15 copay per visit Specialist services may require prior authorization.
Preventive care *Including but not limited to:* • Vaccinations (flu shots, pneumococcal, COVID, etc.) • Cancer screenings • Glaucoma screening • Diabetes screenings • Annual wellness visit • Diabetes self-management training	$0 copay for all Medicare-covered preventive services
Emergency Care • Emergency services • Worldwide emergency coverage	• $150 copay per visit • $0 copay for up to $10,000 in worldwide emergency coverage
Urgently needed services	$0 copay per visit
Diagnostic Services/Labs/ Imaging	For Medicare-covered services, you pay the amounts below. If you receive multiple services on the same day, only the maximum copay applies.

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
• Diagnostic tests & procedures • Lab services • MRI, CAT Scan • X-Rays	• $200 copay • $0 copay • $200 copay • $0 copay Diagnostic procedures, tests, and lab services may require prior authorization and/or a referral.
Hearing Services • Medicare-covered benefits • Routine hearing exam • Hearing aid fittings and evaluations • Hearing aids (all types)	 • $0 copay • $0 copay for up to one exam per year • $0 copay for unlimited hearing aid evaluations/fittings • $149 copay per TruHearing Advanced hearing aid for up to one hearing aid per ear every three years
Dental services Medicare-covered services **Preventive Dental** • Oral exams, cleanings, fluoride treatment, x-rays, and other diagnostic services **Comprehensive Dental** • Restorative Services • Endodontic Services • Periodontic Services • Prosthodontic services • Maxillofacial Prosthetics • Oral and Maxillofacial Surgery	You receive a **$2,000 benefit allowance** every year for preventive and comprehensive dental benefits combined. • $0 copay • $0 copay for preventive services • 20% - 50% of the cost • 20% of the cost • 20% of the cost • 50% of the cost • 20% of the cost • 20% of the cost Comprehensive dental services may require prior authorization and/or a referral.
Vision services • Medicare-covered benefits	• $0 copay, including one pair of Medicare-covered eyewear after cataract surgery

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
• Routine Eye Exam • Routine eyewear (eyeglass lenses, eyeglass frames, and contact lenses)	• $0 copay for unlimited routine eye exams every year • $200 allowance for eyeglass frames and contact lenses (in lieu of eyeglass frames) every year • Eyeglass lenses are unlimited and include single vision, lined trifocal, lenticular and standard progressives. Any costs above the annual allowance is the member's responsibility.
Mental Health Services • Inpatient psychiatric services • Mental health specialty services, including psychiatric services o Individual sessions o Group sessions	• $200 copay per day for days 1 – 4 $0 copay for days 5 – 90 $0 for days 1 – 60 lifetime reserve days Up to 190 days of inpatient psychiatric care for lifetime. • $15 copay for individual sessions • $0 copay group sessions Services may require prior authorization and/or a referral.
Skilled Nursing Facility	$0 copay for days 1 – 20 $221 copay per day for days 21 – 100 100% of all costs for each day after day 100 of the benefit period. Services may require prior authorization and/or a referral.
Outpatient Rehabilitation • Physical therapy • Occupational therapy • Speech therapy	$0 copay Services may require prior authorization and/or a referral.
Ambulance • Ground ambulance	• $0 copay for non-emergency transports

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
• Air ambulance	• $200 copay for all other ground transports • 20% of the cost Non-emergency transport services may require prior authorization.
Transportation (routine)	$0 copay for up to 60 one-way trips to plan-approved health-related locations
Medicare Part B drugs • Insulin • Chemotherapy & other drugs	• 0% - 20% of the cost for Part B drugs • $20.00 copay for a 30-day supply of Part B insulins • 0% - 20% of the cost for other Part B drugs, including chemotherapy
Medical Equipment & Supplies • Durable medical equipment (DME) • Prosthetics • Diabetic therapeutic shoes or inserts • Diabetic monitors	20% of the cost for DME and prosthetics $0 copay for diabetic supplies, diabetic therapeutic shoes or inserts and diabetic monitors DME and prosthetics services may require prior authorization.
Chiropractic • Medicare-covered services • Routine chiropractic care	• $0 copay for Medicare-covered services • $0 copay for routine chiropractic care. See Combined Benefit Package for Chiropractic & Acupuncture below.
Acupuncture • Medicare-covered services • Routine acupuncture treatments	• $0 copay for Medicare-covered services • $0 copay for routine acupuncture treatments. See Combined Benefit Package for Chiropractic & Acupuncture below.
Combined Benefit Package: Chiropractic & Acupuncture	$0 copay for up to 30 total visits per year that can be used for either routine chiropractic care or routine acupuncture treatments.
Outpatient Substance Abuse • Individual sessions	• $15 copay per session

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
• Group sessions	• $0 copay per session Services may require prior authorization and/or a referral.
Renal Dialysis	20% of the cost
Podiatry • Medicare-covered • Routine podiatry	 $0 copay $0 copay for up to 6 routine foot care visits per year Services may require prior authorization and/or a referral.
Annual Physical Exam	$0 copay for a routine annual physical exam Services may require prior authorization. There may be costs associated with any diagnostic radiology services performed with the annual exam.
Flex Card	You pay $0 for a **$375 quarterly** combined allowance to use for any of the following: • Over-the-Counter (OTC) items • Routine Chiropractic Care • Routine Acupuncture Treatments • Therapeutic Massage • Preventive dental services • Comprehensive dental services • Vision eyewear • Prescription Hearing Aids (all types) • Food & Produce (as available under the *SSBCI benefit below)
Enhanced Care **(*Special Supplemental Benefits for the Chronically Ill (SSBCI)) ***	$0 copay for access to healthy foods and produce. This is combined with the Flex Card benefit (above). To qualify for this benefit, you must have one of the following chronic conditions and participate in our care management program: • Cardiovascular disorders; • Chronic heart failure; or • Diabetes mellitus

Premiums and Benefits	MedCare Focus (HMO C-SNP) (H5767-002)
	* The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify.
Meals	$0 copay for up to 3 meals per day for up to 7 calendar days after each inpatient facility discharge. .
Fitness	$0 copay for up to $25 monthly reimbursement on a gym membership or fitness class.
Home & Bathroom Safety Devices & Modifications	$0 copay for a shower chair.
Personal Emergency Response System (PERS)	$0 copay for the PERS benefit to receive emergency alert services from ADT Security Services (ADT). Members will have access to a customizable PERS offering, including three (3) emergency alert solutions: • Medical Alert Basic (PERS Basic): an in-home unit with range of up to 300-feet • Medical Alert Plus (PERS Plus): an in-home unit with 600-foot pendant range • On-The-Go (PERS On-The-Go): Mobile base unit with optional Fall Detection All solutions feature: • Two-way voice communication to ADT monitoring center • Water resistant pendants or wristbands • 24/7/365 monitoring service The optional Fall Detection system pairs with the Medical Alert Plus and On-The-Go solutions and enables members to send an alert to ADT's customer monitoring center automatically when a fall is detected, even if the button is not pressed as well as when the help button is pressed.
Nursing Hotline	$0 copay for 24 hours a day/7 day a week access to a nursing hotline for health-related questions or concerns.
Therapeutic Massage	$0 copay This benefit can be accessed under the Flex Card (above).

Part D Prescription Drugs			
Part D Deductible	$0		
Initial Coverage	In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach **$2,400**.		
	Standard Retail cost sharing (30-day supply)	**Standard Retail cost sharing (90-day supply)**	**Mail Order cost sharing (90-day supply)**
Tier 1 - Preferred Generic (including insulins)	$0 copay	$0 copay	$0 copay
Tier 2 – Generic Insulins	$3 copay $3 copay or 25% of the cost	$9 copay $9 copay or 25% of the cost	$6 copay $6 copay or 25% of the cost
Tier 3 - Preferred Brand Insulins	$30 copay $20 copay or 25% of the cost	$90 copay $60 copay or 25% of the cost	$60 copay $40 copay or 25% of the cost
Tier 4 - Non-Preferred Drug Insulins	$100 copay $35 copay or 25% of the cost	$300 copay $105 copay or 25% of the cost	$200 copay $70 copay or 25% of the cost
Tier 5 - Specialty Tier Insulins	33% of the cost $35 copay or 25% of the cost	Long-term supply not available	Long-term supply not available
Tier 6 - Select Care Drugs (including insulins)	$0 copay	$0 copay	$0 copay
Catastrophic Coverage *(after you or others on your behalf pay $2,400)*	In this stage, you pay nothing for your covered Part D drugs and drugs offered under our enhanced drug benefit. You generally stay in this stage for the rest of the calendar year.		
Cost sharing may change depending on point-of-service (mail-order, retail, LTC, home infusion), the pharmacy you choose and when you enter a new phase of the drug stages.			
Important message about what you pay for insulin	At a retail pharmacy, you won't pay more than 25% of the cost or $35 for a one-month supply of each insulin product covered by our plan (whichever is less).		
Important message about what you pay for vaccines	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.		
Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1.800.772.1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1.800.325.0778.			

Additional Details and Contact Information

Who can join?	**You must:**
	• have both Medicare Part A and Part B
	• live in the plan service area (Harris County Texas)
	• be a United States citizen or be lawfully present in the United States
	• be diagnosed with one of the following conditions:
	  ○ diabetes mellitus
	  ○ chronic heart failure
	  ○ cardiovascular disorders

Member Services Phone Number	**+1-866-MCPTX01 +1 (866) 627-8901**
TTY	**711**
Hours of Operation	**October 1 to March 31:** 8 am to 8 pm, 7 days a week (except Thanksgiving and Christmas Day) **April 1 to September 30:** 8 am to 8 pm, Monday through Friday (except for federal holidays) Messages received on holidays and outside of our business hours will be returned within one business day.
Website	www.mcpartnerstx.com

MedCarePartners
Health Plan of Texas

2027 SUMMARY of BENEFITS

MedCare Choice (HMO C-SNP) H5767-003

Harris County, Texas

Benefits effective January 1, 2027 – December 31, 2027

MedCare Choice (HMO C-SNP)
H5767-003
January 1, 2027 - December 31, 2027

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To join **MedCare Choice (HMO C-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and be diagnosed with one of the following: diabetes mellitus, chronic heart failure, or cardiovascular disorders. Our service area includes the following county in Texas: Harris.

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Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
Monthly Plan Premium *(includes both medical and drugs)*	You pay $6 You must continue to pay your Medicare Part B premium.
Deductible	$283 deductible per year for in-network medical services. This is the 2026 Part B deductible amount and may change for 2027. MedCare Partners Health Plan of Texas will provide the updated amount as soon as it is released. See the Part D Prescription Drugs section for the Part D deductible.
Maximum out-of-pocket responsibility *(Does not include prescription drug costs)*	You pay no more than $9,850 annually for in-network Medicare-covered benefits.

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
Inpatient Hospital	$1,736 deductible per benefit period $0 copay for days 1 - 60 $434 copay per day for days 61 - 90. $868 copay per day for lifetime reserve days after day 90 Services may require prior authorization and/or a referral. These are 2026 cost-sharing amounts and may change for 2027. MedCare Partners Health Plan of Texas will provide updated amounts as soon as they are released.
Outpatient Hospital • Outpatient services • Observation services	20% of the cost Services may require prior authorization and/or a referral.
Ambulatory Surgery Center (ASC)	20% of the cost Services may require prior authorization and/or a referral.
Doctor visits • Primary care providers (PCP) • Specialists	• $0 copay applies to PCP office visits • 20% of the cost applies to PCP services in a facility • 20% of the cost Specialist services may require prior authorization and/or a referral.
Preventive care *Including but not limited to:* • Vaccinations (flu shots, pneumococcal, COVID, etc.) • Cancer screenings • Glaucoma screening • Diabetes screenings • Annual wellness visit • Diabetes self-management training	• $0 copay for all Medicare-covered preventive services

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
Emergency Care • Emergency services • Worldwide emergency coverage	 • $115 copay per visit • $0 copay for up to $10,000 in worldwide emergency coverage
Urgently needed services	$0 copay per visit
Diagnostic Services/Labs/ Imaging • Diagnostic tests & procedures • Lab services • MRI, CAT Scan • X-Rays	For Medicare-covered services, you pay the amounts below. If you receive multiple services on the same day, only the maximum copay applies. • 20% of the cost • $0 copay • 20% of the cost • 20% of the cost Diagnostic procedures, tests, and lab services may require prior authorization and/or a referral.
Hearing Services • Medicare-covered benefits • Routine hearing exam • Hearing aid fittings and evaluations • Hearing aids (all types)	 • $0 copay • $0 copay for up to one exam per year • $0 copay for unlimited hearing aid evaluations/fittings • $149 copay per TruHearing Advanced hearing aid for up to one hearing aid per ear every three years

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
Dental services Medicare-covered services **Preventive Dental** • Oral exams, cleanings, fluoride treatment, x-rays and other diagnostic services **Comprehensive Dental** • Restorative Services • Endodontic Services • Periodontic Services • Prosthodontic services • Maxillofacial Prosthetics • Oral and Maxillofacial Surgery	You receive a **$2,000 benefit allowance** every year for preventive and comprehensive dental benefits combined. • $0 copay • $0 copay for preventive services • 20% - 50% of the cost • 20% of the cost • 20% of the cost • 50% of the cost • 20% of the cost • 20% of the cost Comprehensive dental services may require prior authorization and/or a referral.
Vision services • Medicare-covered benefits • Routine Eye Exam • Routine eyewear (eyeglass lenses, eyeglass frames, and contact lenses)	• $0 copay, including one pair of Medicare-covered eyewear after cataract surgery • $0 copay for unlimited routine eye exams every year • $200 allowance for eyeglass frames and contact lenses (in lieu of eyeglass frames) every year • Eyeglass lenses are unlimited and include single vision, lined trifocal, lenticular and standard progressives Any costs above the annual allowance is the member's responsibility.
Mental Health Services • Inpatient psychiatric services	• $1,736 deductible per benefit period $0 copay for days 1 – 60 $434 copay per day for days 61 - 90. $868 copay per day for lifetime reserve days after day 90 These are 2026 cost-sharing amounts and may change for 2027. MedCare Partners Health Plan of Texas will provide updated amounts as soon as they are released.

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
• Mental health specialty services, including psychiatric services (individual and group sessions)	• 20% of the cost Services may require prior authorization and/or a referral.
Skilled Nursing Facility	$0 copay for days 1 – 20 $221 copay per day for days 21 – 100 100% of all costs for each day after day 100 of the benefit period. Services may require prior authorization and/or a referral.
Outpatient Rehabilitation • Physical therapy • Occupational therapy • Speech therapy	20% of the cost Services may require prior authorization and/or a referral.
Ambulance • Ground and air ambulance	20% of the cost Non-emergent transport services may require prior authorization.
Transportation (routine)	$0 copay for up to 60 one-way trips to plan-approved health-related locations
Medicare Part B drugs • Insulin • Chemotherapy & other drugs	• 0% - 20% of the cost for Part B drugs • $20.00 copay for a 30-day supply of Part B insulins • 0% - 20% of the cost for other Part B drugs, including chemotherapy
Medical Equipment & Supplies • Durable medical equipment (DME) • Prosthetics • Diabetic therapeutic shoes or inserts • Diabetic monitors	20% of the cost for DME, prosthetics and diabetic monitors $0 copay for diabetic supplies and diabetic therapeutic shoes or inserts DME and prosthetics services may require prior authorization and/or a referral.

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
Chiropractic • Medicare-covered services • Routine chiropractic care	• 20% of the cost for Medicare-covered services • $0 copay for routine chiropractic care. See Combined Benefit Package for Chiropractic & Acupuncture below.
Acupuncture • Medicare-covered services • Routine acupuncture treatments	• 20% of the cost for Medicare-covered services • $0 copay for routine acupuncture treatments. See Combined Benefit Package for Chiropractic & Acupuncture below.
Combined Benefit Package: Chiropractic & Acupuncture	$0 copay for up to 30 total visits per year that can be used for either routine chiropractic care or routine acupuncture treatments.
Outpatient Substance Abuse Individual and group sessions	20% of the cost Services may require prior authorization and/or a referral.
Renal Dialysis	20% of the cost
Podiatry • Medicare-covered • Routine podiatry	• 20% of the cost • $0 copay for up to 6 routine foot care visits per year Services may require prior authorization and/or a referral.
Annual Physical Exam	$0 copay for a routine annual physical exam Services may require a prior authorization. There may be costs associated with any diagnostic radiology services performed with the annual exam.
Flex Card	You pay $0 for a **$490 quarterly** combined allowance to use for any of the following: • Over-the-Counter (OTC) items • Routine Chiropractic Care • Routine Acupuncture Treatments • Therapeutic Massage • Preventive dental services • Comprehensive dental services • Vision eyewear

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
	• Prescription Hearing Aids (all types) • Food & Produce (as available under the *SSBCI benefit below)
Enhanced Care **(Special Supplemental Benefits for the Chronically Ill (SSBCI)) ***	$0 copay for access to healthy foods and produce. This is combined with the Flex Card benefit (above). To qualify for this benefit, you must have one of the following chronic conditions and participate in our care management program: • Cardiovascular disorders; • Chronic heart failure; or • Diabetes mellitus * The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify.
Meals	$0 copay for up to 3 meals per day for up to 7 calendar days after each inpatient facility discharge.
Fitness	$0 copay for up to $25 monthly reimbursement on a gym membership or fitness class.
Home & Bathroom Safety Devices & Modifications	$0 copay for a shower chair.
Personal Emergency Response System (PERS)	$0 copay for the PERS benefit to receive emergency alert services from ADT Security Services (ADT). Members will have access to a customizable PERS offering, including three (3) emergency alert solutions: • Medical Alert Basic (PERS Basic): an in-home unit with range of up to 300-feet • Medical Alert Plus (PERS Plus): an in-home unit with 600-foot pendant range • On-The-Go (PERS On-The-Go): Mobile base unit with optional Fall Detection All solutions feature: • Two-way voice communication to ADT monitoring center • Water resistant pendants or wristbands • 24/7/365 monitoring service

Premiums and Benefits	MedCare Choice (HMO C-SNP) (H5767-003)
	The optional Fall Detection system pairs with the Medical Alert Plus and On-The-Go solutions and enables members to send an alert to ADT's customer monitoring center automatically when a fall is detected, even if the button is not pressed as well as when the help button is pressed.
Nursing Hotline	$0 copay for 24 hours a day/7 day a week access to a nursing hotline for health-related questions or concerns.
Therapeutic Massage	$0 copay This benefit can be accessed under the Flex Card (above).
Medicare Cost Sharing	**If you have full Medicaid benefits (FBDE) or are a Qualified Medicare Beneficiary (QMB+) or a Specified Low-income Medicare Beneficiary (SLMB+), you will pay $0 for your Medicare-covered services listed in this chart, including Part B premiums, deductibles, and cost shares.**

Part D Prescription Drugs			
Part D Deductible	$700. This deductible applies to drugs in Tier 2, Tier 3, Tier 4 and Tier 5.		
Initial Coverage	In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach **$2,400**.		
	Standard Retail cost sharing (30-day supply)	**Standard Retail cost sharing (90-day supply)**	**Mail Order cost sharing (90-day supply)**
Tier 1 - Preferred Generic (including insulins)	$0 copay	$0 copay	$0 copay
Tier 2 – Generic Insulins	25% of the cost $35 copay or 25% of the cost	25% of the cost $105 copay or 25% of the cost	25% of the cost $70 copay or 25% of the cost
Tier 3 - Preferred Brand Insulins	25% of the cost $35 copay or 25% of the cost	25% of the cost $105 copay or 25% of the cost	25% of the cost $70 copay or 25% of the cost
Tier 4 - Non-Preferred Drug Insulins	25% of the cost $35 copay or 25% of the cost	25% of the cost $105 copay or 25% of the cost	25% of the cost $70 copay or 25% of the cost
Tier 5 - Specialty Tier Insulins	25% of the cost $35 copay or 25% of the cost	Long-term supply not available	Long-term supply not available
Tier 6 - Select Care Drugs (including insulins)	$0 copay	$0 copay	$0 copay
Catastrophic Coverage *(after you or others on your behalf pay $2,400)*	In this stage, you pay nothing for your covered Part D drugs and drugs offered under our enhanced drug benefit. You generally stay in this stage for the rest of the calendar year.		
Important message about what you pay for insulin	At a retail pharmacy, you won't pay more than 25% of the cost or $35 for a one-month supply of each insulin product covered by our plan (whichever is less), even if you haven't paid your deductible.		
Important message about what you pay for vaccines	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.		
Cost sharing may change depending on point-of-service (mail-order, retail, LTC, home infusion), the pharmacy you choose and when you enter a new phase of the drug stages.			
Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1.800.772.1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1.800.325.0778.			

Additional Details and Contact Information

Who can join?	**You must:**
	• have both Medicare Part A and Part B
	• live in the plan service area (Harris County Texas)
	• be a United States citizen or be lawfully present in the United States
	• be diagnosed with one of the following conditions:
	  ○ diabetes mellitus
	  ○ chronic heart failure
	  ○ cardiovascular disorders

Member Services Phone Number	○ **+1-866-MCPTX01 +1(866) 627-8901**
TTY	**711**
Hours of Operation	**October 1 to March 31:** 8 am to 8 pm, 7 days a week (except Thanksgiving and Christmas Day) **April 1 to September 30:** 8 am to 8 pm, Monday through Friday (except for federal holidays) Messages received on holidays and outside of our business hours will be returned within one business day.
Website	www.mcpartnerstx.com

MedCare Partners
Health Plan of Texas

SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

The Centers for Medicare and Medicaid Services requires licensed sales agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product you want the agent to discuss.	
MedCare Partners Health Plan - Medicare Advantage Plans (HMO, HMO C-SNP):	
These Medicare Advantage Plans provide all Medicare Part A and Part B benefits, and all include Medicare Part D prescription drug coverage (MAPD). Some plans are designed for individuals with specific needs, such as those with chronic conditions (Chronic Condition Special Needs Plans, or C-SNPs).	
☐	**Medicare Advantage HMO (Health Maintenance Organization):** You must use doctors, hospitals, and other providers that are in the plan's network, except in emergencies. You must choose a primary care doctor, and you may be required to obtain referrals to see specialists.
☐	**Medicare Advantage HMO Chronic Condition Special Needs Plans (HMO C-SNP):** These plans are designed for people with specific chronic conditions, such as diabetes, cardiovascular disorders, or chronic heart failure. They tailor benefits, provider choices, and drug formularies to best meet the specific needs of the group they serve.

SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

(Continued)

By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal Government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	
Your Relationship to the Beneficiary:	

To be completed by Agent:

Agent Name:	Agent NPN:
Agent Phone Number:	Agent Email:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address: *(optional)*	
Initial Method of Contact: *(Indicate here if candidate was a walk-in)*	
Agent Signature:	Date Appt. Completed:

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member service representative at +1 (866) 627-8901 TTY 711.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.mcpartnerstx.com or call +1 (866) 627-8901(TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor. Visit www.mcpartnerstx.com or call +1 (866) 627-8901 (TTY 711) for a list of Medicare Partners Health Plan of Texas network providers.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions. Visit www.mcpartnerstx.com or call +1 (866) 627-8901 (TTY 711) for a list of Medicare Partners Health Plan of Texas list of covered medications.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Effective on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

For Special Needs Plans Only

- ☐ MedCare Focus (HMO-POS C-SNP) 002 is a chronic condition special needs plan. Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition. MedCare Choice (HMO-POS C-SNP) 003 is also a chronic condition special needs plan, but you must also qualify for Medicaid or Extra Help/the Low-Income Premium Subsidy (LIPSA).

MedCare Partners
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Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date)_____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicare Managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date)_____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ I already have Medicare Part A (Hospital) and recently signed up for Medicare Part B (Medical). Now I want to join a Medicare Advantage Plan (ICEP).

☐ I had Medicare prior to age 65 and now, I am turning 65 (SEP65)

If none of these statements applies to you or you're not sure, please contact MedCare Partners at +1 (866) 627-8901 (TTY users should call 711) to see if you are eligible to enroll. We are open 7 days a week from 8 a.m. to 8 p.m. between October 1st through March 31st. Then between April 1st through September 30th, we are open from Monday through Friday from 8 a.m. to 8 p.m. Messages received on holidays and outside of our business hours will be returned within one business day.

MedCare Partners
Health Plan of Texas

OMB No. 0938-1378
Expires: 2/28/2029

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
MedCare Partners Health Plan
11602 Bellaire Blvd., Suite C
Houston, TX 77072

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call MedCare Partners Health Plan at 1-866-627-8901. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a MedCare Partners Health Plan al 1-866-627-8901 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ MedCare Classic (HMO) PBP 001 – $0 per month

☐ MedCare Focus (HMO C-SNP) PBP 002 – $0 per month

☐ MedCare Choice (HMO C-SNP) PBP 003 (Chronic & LIPSA) - $6.00 per month

FIRST name:	LAST name:	Middle Initial (Optional):

Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ _ _ _ _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to MedCare Partners Health Plan?
☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

_____

Special Needs Plan Eligibility

Enrollment in some of the plans listed above requires that you have certain chronic conditions. Have you been diagnosed with any of the following chronic conditions (check all that apply):

☐ Diabetes
☐ Congestive Heart Failure (CHF)
☐ Cardiovascular Disorders, including any of these diagnoses:
  ☐ Cardiac arrhythmias
  ☐ Coronary artery disease
  ☐ Peripheral vascular disease or
  ☐ Chronic venous thromboembolic disorder

IMPORTANT: Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in MedCare Partners Health Plan. • By joining this Medicare Advantage, I acknowledge that MedCare Partners Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. • I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans). • I understand that when my MedCare Partners Health Plan coverage begins, I must get all of my medical and prescription drug benefits from MedCare Partners Health Plan. Benefits and services provided by MedCare Partners Health Plan and contained in my MedCare Partners Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MedCare Partners Health Plan will pay for benefits or services that are not covered. • The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. • I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment, and 2) Documentation of this authority is available upon request by Medicare.	
Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Vietnamese ☐ Other: _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact MedCare Partners Health Plan at 1-866-627-8901 if you need information in an accessible format other than what's listed above. Our office hours are 8:00am to 8:00pm local time, 7 days a week from October 1 through March 31 and 8:00am to 8:00pm, Monday through Friday from April 1 through September 30. TTY users can call 711.

Section 2 – All fields in this section are optional

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP): _____

Address: _____ Phone: _____ Fax/Email: _____

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Provider/Pharmacy Directory ☐ Formulary (Drug List) ☐ Member Newsletter

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay MedCare Partners Health Plan the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Effective Date of Coverage: _____ Agent Submission Date to Plan: _____

Enrollment Period: ☐ AEP ☐ ICEP ☐ SEP type: _____ ☐ MA OEP

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

MedCare Partners
Health Plan of Texas

Member First Name: _____
Member Last Name: _____

Address (City/State/Zip): _____
_____
Phone Number: _____
Date of Birth (mmddyy): _____
Plan Type: CSNP
MedCare Partners Member ID: _____
Medicare Number (MBI #): _____
Person Completing this form: _____
Relationship to Member: _____

Health Risk Assessment (HRA) Tool

This information will help us understand your health needs.

Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s).

Direct questions about this form to 1 (866) 627-8901 (TTY: 711)).

Today's date is: _____, 202___

1. Right to Consent or Decline

I ☐ **Accept/Opt In** or ☐ **Decline/Opt Out** to participate in MedCare Partners Health Plan of Texas' Health Risk Assessment Tool (HRAT)

2. Physical Health Rating

2.1. What is your height _____(inches only) **2.2. What is your weight** _____(pounds)

2.2.	**Are you concerned about your health**	☐ Yes ☐ No
2.3.	**Do you feel you get enough physical activity/exercise**	☐ Yes ☐ No
2.4.	**Do you feel that your diet supports a healthy lifestyle**	☐ Yes ☐ No

3. Activities of Daily Living

3.1. How much help do you need with the following?

Activity	No Help Needed	Some Help Needed	Can't Do at All
3.1.1. Bathing	☐	☐	☐
3.1.2. Dressing	☐	☐	☐
3.1.3. Eating	☐	☐	☐
3.1.4. Getting out of bed or chair	☐	☐	☐
3.1.5. Preparing meals	☐	☐	☐
3.1.6. Taking your medicine	☐	☐	☐
3.1.7. Using the bathroom	☐	☐	☐
3.1.8. Walking	☐	☐	☐
3.1.9. Transportation	☐	☐	☐

3.2. Where do you currently live ☐Private Home ☐Assisted Living ☐Nursing Home ☐Group Home ☐Apartment ☐Condo ☐Half-way House ☐Trailer/Mobile Home Park ☐Homeless ☐Other

3.3. If you need help, do you have someone close by or a caregiver who helps you
☐Family ☐Friend ☐Neighbor ☐Caregiver ☐No help ☐I prefer not to answer ☐Other

3.4. Medical Equipment (check all that apply) ☐Walker ☐Wheelchair ☐Hospital Bed ☐Oxygen ☐Nebulizer ☐Portable Toilet ☐Shower Chair ☐C-pap/Bi-pap ☐Other

4. Social Determinants of Health

4.1. Is there anything preventing you from taking steps to get the care you need? ☐ Yes ☐ No ☐ N/A

If yes, check all that apply ☐Transportation ☐Cost of Medical Services ☐Cost of Medications ☐Access to Services ☐Care Giver Support ☐Language differences ☐Cultural differences ☐Hard of hearing ☐Visual difficulties ☐Family objections ☐Social issues: discrimination/distrust ☐Mental health issues/ distrust some people ☐Domestic violence /abuse ☐Elder abuse ☐Other

5. Clinical Health History & Treatment

5.1. What is the name of your Primary Care Physician (PCP)? _____

5.2. Do you need a PCP? ☐I need a new PCP ☐No

5.3. When did you last see your Primary Care Physician? ☐Less than 6 mo. ☐More than 6 mo. ☐12 mo. or greater

5.4. How many times were you admitted to the Hospital or Emergency Room in the past 12 months?
☐ 0 ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times

5.7. Have you been in a post-acute facility (skilled nursing, rehabilitation, or long-term care) in the past 12 months? ☐ 0 ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times

5.8. Please check Yes or No and include Treating Provider(s) for the following conditions:

5.8.1. Asthma or Chronic Bronchitis ☐ Yes ☐ No	**5.8.15. Stroke, Heart Attack, Chest Pain, or Blocked Arteries** ☐ Yes ☐ No
5.8.2. COPD or Emphysema ☐ Yes ☐ No	**5.8.16. Congestive Heart Failure (CHF)** ☐ Yes ☐ No
5.8.3. Shortness of Breath or Breathing Problems ☐ Yes ☐ No	**5.8.17. Circulation Problems** ☐ Yes ☐ No
5.8.4. Frequent Falls ☐ Yes ☐ No	**5.8.18. High Blood Pressure** ☐ Yes ☐ No
5.8.5. Osteoporosis ☐ Yes ☐ No	**5.8.19. Swelling (ankle or leg)** ☐ Yes ☐ No
5.8.6. Osteoarthritis ☐ Yes ☐ No	**5.8.20. Diabetes** ☐ Yes ☐ No ☐Type 1 ☐Type 2 ☐Pre-Diabetes ☐Gestational
5.8.7. Recent Fracture ☐ Yes ☐ No	**5.8.21. Skin Ulcer, Non-Healing Wound, Sores** ☐ Yes ☐ No
5.8.8. Parkinson's/ALS/MS/Lupus ☐ Yes ☐ No	**5.8.22. Organ Transplant** ☐ Yes ☐ No
5.8.9. Cancer ☐ Yes ☐ No	**5.8.23. Memory Loss, Dementia, or Alzheimer's** ☐Yes ☐ No
5.8.10. HIV/AIDS ☐ Yes ☐ No	**5.8.24. Urinary Incontinence or Bladder Control Problems** ☐ Yes ☐ No
5.8.11. Depression ☐ Yes ☐ No	**5.8.25. Frequent Urinary Track Infections** ☐ Yes ☐ No
5.8.12. Serious Mental Illness ☐ Yes ☐ No	**5.8.26. Kidney Failure or End Stage Renal Disease (ESRD)** ☐ Yes ☐ No
5.8.13. Eyes: Blindness or trouble seeing even when wearing glasses ☐ Yes ☐ No	**5.8.27. Bowel Problems** ☐ Yes ☐ No
5.8.14. Ears: Deafness or trouble hearing even when wearing a hearing aid? ☐ Yes ☐ No	**5.8.28. Other** ☐ Yes ☐ No

6. Life Planning Activities

6.1. Do you have or need the following: Advance Health Care Directive such as a Living Will or Physician Orders for Life-Sustaining Treatment (POLST)? ☐Yes ☐No ☐I need one

7. Preventative Health Maintenance

HEALTH RISK ASSESSMENT TOOL

7.1.	**Do you get a flu vaccine/shot annually?**	☐ Yes ☐ No
7.2.	**Have you received a Covid vaccine/shot in the year?**	☐ Yes ☐ No
7.3.	**Have you had a colon cancer check /screening in the last 10 years?**	☐ Yes ☐ No
7.4.	**Have you had a pap test in the past 2 years?**	☐ Yes ☐ No ☐ N/A
7.5.	**Have you had a mammogram in the past 2 years?**	☐ Yes ☐ No ☐ N/A
7.6.	**Do you use tobacco (smoke, chew, snuff, or in any other form)?**	☐ Yes ☐ No
7.7.	**Does drinking alcohol interfere with your personal or work life?**	☐ Yes ☐ No
7.8.	**Frequency of Pain in the past week?**	☐No pain ☐Pain some days ☐Pain every day
7.9.	**Pain Management medication or other therapies?**	☐ Yes ☐ No

8. Behavioral & Mental Health

8.1. Over the past 2 weeks, how often have you been bothered by any of the following feelings?

8.1.1.	Feeling down, depressed, hopeless	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.2.	Little interest/pleasure in doing things	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.3.	Crying Spells	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.4.	Difficulty Sleeping	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.5.	Nervousness / Anxious / Worried	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.6.	Agitated / Irritable / Angry	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.7.	Thought of hurting myself or others	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day

8.2. Do personal or family health issues result in loss of work or daily activities? ☐ Yes ☐ No ☐Unsure ☐ N/A

8.3. What stressors do you have at the moment (check all that apply)? ☐Relationships ☐Family ☐Children ☐Lack of Social Support ☐Occupation ☐General Physical Health ☐Financial ☐Other ☐N/A

9. Cultural and Linguistic Needs

9.1. Do you identify with a religion or spiritual tradition? ☐ Atheism/Agnosticism ☐ Buddhism ☐ Catholicism ☐ Christianity ☐ Christian Science ☐ Hinduism ☐ Islam ☐ Jehovah's Witness ☐ Judaism ☐ Mormon ☐ Other ☐ None / Unaffiliated ☐ I prefer not to answer

9.2. What is your primary language? ☐ English ☐ Spanish ☐ French Creole ☐ Vietnamese ☐ Tagalog ☐ I prefer not to answer ☐ Other

9.3. How do you describe your ethnicity? ☐White or Caucasian ☐Black or African American ☐Hispanic /Latino ☐Native American Indian /Alaskan Native ☐Asian ☐Pacific Islander /Native Hawaiian ☐Unknown ☐I prefer not to answer ☐Other

10. Demographics

10.1. What gender do you identify? ☐Male ☐Female ☐Intersex ☐Trans ☐Non-conforming ☐Personal ☐Eunuch ☐ I prefer not to answer ☐Other _____

10.2. Who do you currently live with? ☐Alone ☐Child(ren) ☐Extended Family ☐Friend(s) ☐Parent(s) ☐Roommate(s) ☐Sibling(s) ☐ Spouse/Partner ☐Other _____

11. Housing

11.1. Do you have the following problems (check all that apply)? ☐Bugs ☐Rodents ☐Lead/Asbestos ☐Mold ☐Electric Issues ☐Heating Issues ☐Water Issues ☐ House not safe ☐No issues ☐Other _____

11.2. Do you have internet access (check all that apply)? ☐Computer ☐Phone ☐Tablet ☐Other _____

MedCare Partners
Health Plan of Texas

Care | Connection | Community

Helping You Live Healthier. Longer.

Provider Verification Form

To qualify for a Chronic Care Specials Needs Plan (C-SNP), members must have a qualifying condition.

Please complete and return this form to:

Fax: 1-888- 207-0789
Questions: 1-866-MCPTX01 (1-866-627-8901)

1. MEMBER INFORMATION

Member First Name:	Member Last Name:
Member ID:	Date of Birth (MM/DD/YYYY):

Plan Name: ☐ **MedCare Focus (C-SNP)** ☐ **MedCare Choice (C-SNP)**

2. QUALIFYING CHRONIC CONDITION

Please check the member's qualifying condition. The member must have at least one of the conditions below to be eligible.

☐ **Diabetes**

☐ Chronic **heart failure**

☐ Cardiovascular **disorders** (e.g., arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder)

3. PROVIDER ATTESTATION

☐ **I attest that the above-named member has the qualifying chronic condition checked above.**

☐ **I attest that the above-named member does *not* have any of the above qualifying chronic conditions.**

Provider Name (Please Print):	Title:
Practice Name:	Phone:
Provider Signature:	Date (MM/DD/YYYY):

Important:

- This form must be completed and signed by the member's treating provider (MD, DO, NP, or PA).
- Having a qualifying condition does not automatically guarantee the benefit. Final eligibility is determined by MedCare Partners Health Plan of Texas in accordance with CMS requirements.
- Please return this form via the fax number **1-888- 207-0789**

Notice of Non-Discrimination

MedCare Partners Health Plan of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MedCare Partners Health Plan of Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation, gender identity, or religion.

MedCare Partners Health Plan of Texas provides free aids and services to individuals with disabilities to assist them in communicating effectively with the health plan. Such services may include but are not limited to qualified sign language interpreters, and written information in various formats such as large print, audio, accessible electronic formats, and others.

MedCare Partners Health Plan of Texas provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or believe that MedCare Partners Health Plan of Texas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender identify, contact MedCare Partners Health Plan of Texas Member Services at 1-866-MCPTX01 (+1 (866) 627-8901) (TTY 711) 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31 (except Thanksgiving and Christmas Day) and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30 (except for federal holidays). This call is free. You can also write to us at:

MedCare Partners Health Plan of Texas
Attn: Grievance Department
11602 Bellaire Blvd
Suite C
Houston, TX 77072

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS

English
ATTENTION: If you speak English, language assistance services and auxiliary aids and services, free of charge, are available to you. Call +1 (866) 627-8901 (TTY: 711).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística y ayudas y servicios auxiliares. Llame al +1 (866) 627-8901 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ và các hỗ trợ và dịch vụ phụ trợ miễn phí dành cho bạn. Gọi số +1(866) 627-8901 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務、輔助援助和服務。請致電 +1(866) 627-8901 (TTY: 711)。

Arabic
لك بالمجان. اتصل برقم ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية والمعينات والخدمات المساعدة تتوفر (TTY: 711).8965-627-833

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, mayroong mga de-kalidad na serbisyo sa tulong sa wika at mga pantulong na aid at serbisyo na walang bayad para sa iyo. Tumawag sa +1(866) 627-8901 (TTY: 711).

Urdu
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مدد کی خدمات اور معاون امداد اور خدمات مفت دستیاب ہیں۔ کال کریں 711) 866-627 8901 :(TTY -

French
ATTENTION : Si vous parlez français, des services d'aide linguistique et des aides et services auxiliaires vous sont proposés gratuitement. Appelez le +1(866) 627-8901 (ATS : 711).

Hindi
धयान दें: यदि आप हि बोलीते हैं, तो आपकेलिए मु त में भाषा सहायता सेवाएं और सहायक साधन और सेवाएं उपलबध ह +1(866) 627-8901 (TTY: 711) पर कॉल करें।

Persian / Farsi
توجه: گر به زبان فارسی گفتگو می شود، تسهیلات زبانی و خدمات و ابزارهای کمکی ارزان قیمت برای شما فراهم می باشد. با 833-627-8901 (TTY: 711) تماس بگیرید.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen sowie zusätzliche Hilfsmittel und Dienste zur Verfügung. Rufnummer:+1(866) 627-8901 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스 및 보조 장치와 서비스를 무료로 이용하실 수 있습니다. +1(866) 627-8901 (TTY: 711)번으로 전화해 주십시오.

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ અને સહાયક સાધનો અને સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો +1(866) 627-8901 TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, вам бесплатно доступны услуги языковой помощи, а также вспомогательные средства и услуги. Звоните +1(866) 627-8901 (телетайп: 711).

Bengali
লক্ষ করুন: আপনি যদি বাংলা বলতে পারেন, তবে আপনার জন্য বিনামূল্যে ভাষা সহায্য পরিষেবা এবং সহায়ক পরিষেবা উপলব্ধ রয়েছে। কল করুন +1(866) 627-8901 (TTY:711)।

Swahili
KUMBUKA: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha na vifaa na huduma za ziada zinapatikana kwa ajili yako bila malipo. Piga simu kwa +1(866) 627-8901 (TTY: 711).