Certificate of Coverage

Humana Integrated Care Program of Illinois

Humana®

ILHHU9REN 0117

Certificate of Coverage for Humana Integrated Care Program of Illinois

How to Use Your Certificate of Coverage

Please read this Certificate of Coverage very carefully. Reading just a few of the items or pages may not help you fully understand what you may want to know.

This Certificate of Coverage may be subject to amendment, modification, or termination by mutual agreement between Humana Health Plan, Inc. (the Health Plan) and the Illinois Department of Healthcare and Family Services ("Department") without the consent of any member. Members will be notified of any such changes as soon as possible after they are made. All applications and any amendments of the Certificate of Coverage shall constitute the entire agreement between the parties. No portion of the charter, by-laws or other document of Humana shall be part of this Certificate of Coverage.

By choosing or accepting health care coverage under Humana Health Plan, Inc., members agree to all the terms and conditions in this Certificate of Coverage. In the event of any inconsistency between your Description of Coverage and the contract or the Certificate of Coverage, the terms of the contract or the Certificate of Coverage will control.

Description of Coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in Health Plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions (including external independent reviews).
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in this document. Since the Description of Coverage is not a legal document, for full benefit information please refer to your Certificate of Coverage. In the event of any inconsistency between your Description of Coverage and certificate, the terms of the certificate will control. This Certificate of Coverage replaces and supersedes any previous issued certificates.

For general assistance and information, please contact the Illinois Department of Healthcare and Family Services at 800-226-0768. Please be aware that the Illinois Department of Healthcare and Family Services will not be able to provide specific Health Plan information. For this type of information you should contact your Health Plan directly.

Service Area

Counties of Cook, DuPage, Kane, Kankakee, Lake, and Will and additional counties as approved by the Illinois Department of Healthcare and Family Services.

Exclusions and Limitations

Excluded services include: services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment; services that are provided through a Local Education Agency (LEA); services that are experimental or investigational in nature; services that are provided by a non-Affiliated Provider and not authorized by Health Plan, unless contractually required; services that are provided without a required Referral or prior authorization as set forth in the provider handbook; Medical and surgical services that are provided solely for cosmetic purposes; and diagnostic and therapeutic procedures related to infertility or sterility.

The following services and benefits shall be limited as Covered Services: termination of pregnancy may be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Enrollee's medical record. Termination of pregnancy shall not be provided to enrollees who are eligible under the State Children's Health Insurance Program (215 ILCS 106).

Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the enrollee's medical record.

If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Member's medical record.

Pre-certification and Utilization Review

For non-emergency care, the Member's PCP participates in and concurs with all inpatient hospital stays by pre-approving all elective admissions, outpatient surgery and specialty services. In addition to the PCP's pre-approval of all elective admissions, the Health Plan's Utilization Management ("UM") department must authorize all hospital admissions. The PCP or specialist by referral will make the necessary arrangements for hospitalization, outpatient procedures or other services if medically Necessary as defined in the Certificate of Coverage.

Emergency Care

In an emergency, a Member should immediately seek medical care from the nearest hospital emergency department. Medically Necessary Emergency Services are covered regardless of whether or not the Emergency Services are provided by a Participating Provider. Medically Necessary Post-Stabilization Medical Services provided by a non-Participating Provider are covered if either pre-approved by Health Plan or if Health Plan does not deny approval for such Post-Stabilization Medical Services within one hour of the non-Participating Provider's good faith attempt to obtain approval for such services from Health Plan.

Primary Care Provider ("PCP") Selection

Members must choose a PCP from the provider directory available at the time of enrollment. Member's PCP is responsible for providing and coordinating care, approving referrals to specialists and other services. Members may change their PCP by calling Member Services at 1-800-764-7591 (TTY: 711).

Out-of-Area Coverage

Out-of-Area coverage is available only for emergency care and dialysis. Once the condition has been stabilized, the Member must return to the Service Area as soon as medically appropriate to receive continuing and/or follow-up care.

Access to Specialty Care

A Member may see a specialist Participating Provider for Medically Necessary services, if Member obtains a referral from Member's PCP. The PCP must approve services or additional referrals recommended by specialist Participating Providers. In some situations, a Member may request a standing referral to a specialist who is a Participating Provider.

If a Member's PCP determines a referral to a specialist is appropriate for Medically Necessary services and a qualified specialist who is a Participating Provider does not exist, the PCP may approve a referral to a specialist who is not a Participating Provider; provided, however, that the specialist is an Illinois Medical Assistance Program Provider.

Female Members may choose, in addition to a PCP, a family practitioner or obstetrician/gynecologist, who is also a Participating Provider, as her Woman's Health Care Provider ("WHCP"). After this selection, Member may see her designated WHCP without a referral for all Covered Services. At the request of any WHCP, the Health Plan shall follow its utilization and quality assurance procedures and protocols in evaluating the WHCP as a PCP.

Members who need behavioral health services may access the Health Plan's subcontracted behavioral health provider without a referral. Also, Members may seek family planning services out of network and these services will be covered by the Department.

Financial Responsibility

There are no copayments, deductibles or premiums payable by the Member for covered, eligible care.

Continuity of Care

Subject to certain conditions described in greater detail in the Certificate of Coverage, a new Member, who either requires an ongoing course of treatment or who is in her third trimester of pregnancy, may request to continue to see their existing Specialty Physician until ninety (90) days after the effective date of coverage, in the case of an ongoing course of treatment, and including post-partum care directly related to delivery in the case of pregnancy.

Subject to certain conditions described in greater detail in the Certificate of Coverage, if an existing Member's Participating Physician leaves Health Plan's network and the existing Member is either receiving an ongoing course of treatment from the Participating Physician, or the existing Member is in her third trimester of pregnancy and is receiving care from the Participating Physician, the existing Member may request to continue to see that physician for ninety (90) days from the date Health Plan notifies Member that the physician is leaving the Health Plan's network.

In either case, the physician must agree to the Health Plan's Quality Improvement and Utilization Plan policies and procedures, and payment.

Certificate of Coverage

This Certificate of Coverage is issued by Humana Health Plan, Inc., operating as a health maintenance organization. In consideration of the Member's enrollment in Humana Integrated Care Program of Illinois, Humana Health Plan, Inc. shall provide and/or arrange for covered health care services to the Member in accordance with the provisions of this Certificate of Coverage.

IN WITNESS WHEREOF, Humana Health Plan, Inc., has caused this Certificate of Coverage to be executed by its duly authorized officer on the date indicated below, under which Certificate coverage will begin on the Effective Date indicated below.

Effective Date:

_____

Humana Health Plan, Inc.

By 

President and CEO

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Definitions

A. **"Action"** means a (i) denial or limitation of authorization of a requested service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) denial of payment for a service; (iv) failure to provide services in a timely manner; (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Service Area. (v) failure to respond to an appeal in a timely manner; and (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Contracting Area.

B. **"Appeal"** means a request for review of a decision made by the Health Plan with respect to an Action.

C. **"Chronic"** means an illness or injury that is, or is expected to be, but is not necessarily, of a long duration and/or frequently recurs and is always present to a greater or lesser degree. Chronic conditions may have acute episodes.

D. **"Complaint"** means a phone call, letter or personal contact from a Participant, Member, family member, Member representative or any other interested individual expressing a concern related to the health, safely or well-being of a Member.

E. **"Contract"** means the agreement between Health Plan and the Department under which this coverage is made available to Eligible Persons.

F. **"Covered Services,"** as described more fully on Page 6, are those benefits, services, and supplies which Health Plan, Inc., ("Health Plan") has contracted with the Department to arrange for Members.

G. **"Department"** shall mean the Illinois Department of Healthcare and Family Services.

H. **"Dependent"** shall mean an individual meeting the requirements under the Medical Assistance Program who is a member of a medical assistance case and an Eligible Person.

I. **"Effective Date"** shall mean the date on which a Member's coverage becomes effective.

J. **"Eligible Person"** shall mean any person covered under the Contract.

K. **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. serious impairment to bodily functions ; or
3. serious dysfunction of any bodily organ or part

L. **"Emergency Services"** means those inpatient and outpatient health services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a provider qualified to furnish emergency services.

M. **"EPSDT"** shall mean Early and Periodic, Screening, Diagnosis, and Treatment services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.).

N. **"Exclusion,"** as more fully described on Page 19, is an item or service which is not a Covered Service under the Contract.

O. **"Grievance"** means a Member's expression of dissatisfaction, including complaints, about any matter other than a matter that is properly the subject of an Appeal.

P. **"Hospital"** is a legally operated facility defined as an acute care or tertiary hospital and an institution licensed by the State and approved by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the American Osteopathic Association ("AOA") or by the Medicare program.

Q. **"Medical Assistance Program"** means the HFS Medical Assistance Program administered by the Illinois Department of Healthcare and Family Services.

R. **"Medical Director"** means a Physician designated by Health Plan to monitor and review the utilization and quality of health services provided to Members.

S. **"Medically Necessary"** means that a service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to enable the Member to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with the Health Plan's guidelines, policies, and/or procedures.

T. **"Member"** shall mean an Eligible Person enrolled in the Health Plan under the Contract.

U. **"Out-of-Area Services"** are those Covered Services arranged or received outside the Service Area and are limited to Emergency Services.

V. **"Participating Provider"** is a Provider who, at the time of providing or prescribing Covered Services to a Member, has contracted directly or indirectly with Health Plan to provide and/or coordinate Covered Services and is currently enrolled as a provider in the Medical Assistance Program. A Participating Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Participating Physician.

W. **"Participating Provider"** is a Provider, medical group, Hospital, Skilled Nursing Facility, home health agency, or any other duly licensed institution or health professional that has contracted directly or indirectly with Health Plan to provide or facilitate Covered Services to Members, and is currently enrolled as a provider in the Medical Assistance Program. A Participating Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Participating Provider.

X. **"Physician"** is a person licensed under the Medical Practice Act of 1987.

Y. **"Post-Stabilization Services"** means medically necessary non-emergency services furnished to a Member after the Member is Stabilized, in order to maintain such Stabilization, following an Emergency Medical Condition.

Z. **"Primary Care Provider"** means a Participating Provider who has primary responsibility for providing, arranging and coordinating all aspects of a Member's health care. A Member shall select or have selected on his or her behalf a Primary Care Provider. A Primary Care Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Primary Care Provider.

AA. **"Service Area"** means the geographic area within which Health Plan has received regulatory approval to operate and is designated by the Contract under which the Member is enrolled.

BB. **“Skilled Nursing Care”** means Covered Services that can only be performed by, or under the supervision of, licensed nursing personnel.

CC. **“Skilled Nursing Facility”** is a facility which is duly licensed by the State which provides inpatient acute skilled nursing care, acute rehabilitation services or other related acute health services.

DD. **“Specialty Care Physician”** is a Physician who provides certain specialty medical care upon referral by a Member’s Primary Care Physician and is currently enrolled as a provider in the Medical Assistance Program and authorized by Health Plan.

EE. **“Stabilization or Stabilized”** means, with respect to an Emergency Medical Condition, and as determined by an attending emergency room Physician or other treating provider within reasonable medical probability, that no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

FF. **“Usual and Customary Charge**” is the charge which is based on the then current prevailing Medical Assistance Program fee schedule in the Member’s Service Area. If a Member has a question as to Health Plan’s determination of the Usual and Customary Charge in a specific instance, he or she may call Member Services.

GG. **“Woman’s Primary Health Care Provider”** (“WHCP”) is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who is a Participating Physician and chooses to act as a WHCP.

Member Services

Members' who have questions may call Health Plan Member Services at 1-800-764-7591 (TTY: 711). Member Services is available Monday – Friday, from 8 a.m. – 8 p.m. Central time. However, please note that Health Plan's automated phone system may answer Member calls after hours, during weekends, and holidays. Members should leave their name and telephone number, and Health Plan will return the Members call by the end of the next business day. Members may visit **Humana.com** for twenty-four (24) hour access to information like claims history, eligibility, Health Plan's drug list, physician finder and additional health news and information.

Eligibility, Enrollment and Disenrollment

Eligibility

An Eligible Person who has enrolled in Health Plan pursuant to the Contract and confirmed by the Department.

Nondiscrimination

The Health Plan will not discriminate on the basis of health status or need for health services. Enrollment shall be without regard to race, color, religion, sex, national origin, ancestry, age or physical or mental handicap.

Confirmation of Health Plan Enrollment

Upon enrollment, Members will receive a welcome letter and an ID card. The ID card has the effective date of enrollment. They will also receive a member welcome packet. Members should also receive a welcome call within thirty (30) days of your enrollment.

Open Enrollment

If the Member is new to the Health Plan, they will have 90 days from the effective date of their first enrollment to change their health plan. During the first 90 days, Members can change health plans for any reason. If they change their health plan, they will have 90 days during which they may go back to their original health plan. After 90 days they will stay enrolled in the plan until their annual open enrollment period.

The annual enrollment period is one (1) year from the Member's effective date. The Member will receive a letter from Illinois Client Enrollment Services (ICES) ninety-five (95) calendar days prior to their annual effective date. The letter will say that the Member can change health plans if they want to. The letter will give them the dates that they can make the change. The Member will have sixty (60) days to change. This sixty (60) day period is called open enrollment. Members can change health plans during their sixty (60) day open enrollment period every year. Members do not have to change health plans, but they can if they want to. If Members choose to change plans during open enrollment, they will be a Member in the new plan at the start of their new enrollment period. Whether the Member picks a new plan or stays with the Health Plan, they will be locked in to that plan for the next twelve (12) months.

Disenrollment and Termination of Coverage

Members may disenroll at any time under procedures established by the Department.

Under certain circumstances, the Health Plan can ask the Department to disenroll or terminate a Member from our Health Plan under procedures established by the Department. This is called “disenrollment for cause.” We can ask that the Member be disenrolled for cause for reasons like:

- The Member moves out of the service area
- The Member becomes eligible for Medicare

Coverage under this Certificate will not be terminated based upon the Member’s health status or if the Member exercises their right to use the Health Plan’s Grievance Procedure.

Reinstatement

If the Member’s coverage is terminated due to losing eligibility, and if eligibility is regained within two (2) calendar months, coverage will automatically be reinstated and the Member will be assigned to their previous PCP and covered under this Certificate. If eligibility is not regained within two (2) calendar months, membership will not be automatically reinstated. The Member will be required to complete a new enrollment application.

COVERED SERVICES

The Health Plan shall comply with the terms of 42 C.F.R. §438.206(b) and provide or arrange to have provided to all Members services described in 89 Ill. Adm. Code, Part 140 as amended from time to time and not specifically excluded therein in accordance with the terms of the Contract. Covered Services shall be provided in the amount, duration and scope as set forth in 89 Ill. Adm. Code, Part 140 and the Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. Initially, Covered Services will be phased in as two (2) service packages as follows:

Service Package I.
The Health Plan shall provide, or arrange for the provision of, Covered Services for Service Package I, which includes all of the services and benefits set forth below, to Members at all times during the term of this Certificate, whenever Medically Necessary, except to the extent services are identified as excluded services.

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Abortions	Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation	Covered benefit when necessary to preserve the woman's life or health or when the pregnancy is the result of rape or incest.	$0
Advanced Practice Nurse Covered Services	Medical and Preventive services provided by Certified Nurse Midwives, Certified Nurse Practitioners and Certified Pediatric Nurse Practitioners	Covered benefit. Prior authorization and referral may be required.	$0
Ambulatory Surgery	• Preoperative examinations • Operating and recovery room services • All required drugs and medicines	Covered benefit.	$0
Behavioral Health	Behavioral health services including but not limited to: • Behavioral health assessment and/or psychological evaluation • Medication management • Community treatment and support, including peer specialists or family peer specialist support services • Therapy/counseling • Services in Community Mental Health • Centers (CMHC's) • Services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option	Covered benefit. Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Behavioral Health *(continued)*	Sub-acute alcohol and substance abuse treatment, including but not limited to: • Outpatient treatment • Residential treatment • Detoxification • Psychiatric evaluation services • Day treatment	Covered benefit. Prior authorization, referral, and other limits may be required.	$0
Chiropractic	Services are limited to the treatment of the spine by manual manipulation to correct a subluxation of the spine.	Covered benefit for members under age 21. Prior authorization and referral may be required. Non covered services: • Services provided to members 21 years of age and older • Services provided to members in group care facilities by a provider who derives direct or indirect profit from total or partial ownership of such facility • Office visits – Diagnostic or screening • Treatment when a definitive pathology is not present • Maintenance therapy	$0
Cosmetic procedures or surgery	The plan covers cosmetic surgery when it is medically necessary because of accidental injury or to improve the function of a malformed body part.	Medically Necessary covered benefit. Prior authorization and referral may be required.	$0
Dental	• "Practice" visits for members with developmental disabilities or serious mental illness to become more comfortable with the dentist's office. Below benefits are for those under 21 years of age • Oral exams limited to every 6 months in an office setting and one every 12 months in a school setting. • Cleanings limited to once every 6 months in an office or school setting. • X-Rays (including Bitewings, Panoramic Film)	Covered benefit. Call DentaQuest toll free at 1-855-343-7400 TTY: 1-800-466-7566 Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Dental (continued)	• Fluoride treatments limited to once every 6 months in an office or school setting. • Sealants • Fillings • Crowns • Root canals • Dentures (full or partial) • Maxillofacial Prosthetics • Extractions (pulling) • Space Maintainers • Pulpotomy • Gingivectomy • Scaling & Root Planing • Bridge • Alveoloplasty • Orthodontic Services • Anesthesia • Sedation • Therapeutic Drug Injection Below benefits are for those over 20 years of age • Oral exams (every 6 months) • X-Rays(including Bitewings, Panoramic Film) • Prophylaxis-Cleaning (once every 6 months) • Fillings • Sedation • Crowns • Root Canals • Alveoloplasty • Dentures (full) • Therapeutic Drug Injection • Extractions • Maxillofacial Prosthetics • Anesthesia	Covered benefit. Call DentaQuest toll free at 1-855-343-7400 TTY: 1-800-466-7566 Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Dental (continued)	Pregnant Adults Services necessary for the health of a pregnant woman prior to the delivery of her baby including: Oral exams Prophylaxis Scaling & Root Planing Full mouth debridement to enable comprehensive periodontal evaluation	Covered benefit. Call DentaQuest toll free at 1-855-343-7400 TTY: 1-800-466-7566 Prior authorization, referral, and other limits may be required.	$0
Dialysis – Outpatient	Outpatient dialysis treatments	Covered benefit.	$0
Durable and Non-Durable Medical Equipment and Supplies	Nondurable medical supplies, including, but not limited to: • Asthma medical supplies such as peak flow meter (not including medicine) • Diabetes testing supplies such as glucometer (not including medicine) Durable medical supplies (DME) including but not limited to: • Diabetic shoes and inserts • Orthoses • Wheelchairs • Oxygen supplies including respiratory equipment • Apnea monitors • Speech generating devices	Covered benefit. Prior authorization may be required and other limits may apply. The member must use a medical supply company or pharmacy that is in-network.	$0
Early and Periodic Screening Diagnostic and Treatment Services (EPSDT)	Comprehensive screening, vision, dental, hearing, treatment, immunizations and diagnostic services needed to correct and improve health conditions based on certain federal guidelines.	Covered benefit for members under age 21. Prior authorization and referral may be required.	$0
Emergency Room	You may go to any emergency room if you reasonably believe you need emergency care.	Covered benefit.	$0
Emergency Transportation	Medically necessary ambulance services	Covered benefit.	$0

Covered Services

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Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Eye Care	• Routine eye exam (1 per year) • Glasses (1 pair per year) • Medically necessary contact lenses or glasses • A replacement frame may be covered only when the present frame is broken, and is non-repairable, or has been lost This includes lenses and frames • New frame parts, including fronts, temples, etc., are covered when used to repair an existing frame • If one or both lenses are broken, but the frame is still usable, the lens or lenses may be replaced Only when Medically Necessary: • Eye exams • Contact lens/lenses and related service • Artificial eye • Low vision devices • Polycarbonate eyeglass lenses for adults, age 21 and over (Polycarbonate lenses for children through age 20 do not require prior approval.)	Covered benefit. Call EyeMed toll free at 1-888-289-0595. Limitations on routine exams: • 1 per year Limitations on contact lenses or glasses: • 1 pair per year for members under age 21 • 1 pair every 2 years for members ages 21 and over	$0
Family Planning	Including but not limited to: • Provider visit • Birth control and family planning education and counseling • Contraceptives (birth control) • Testing for sexually transmitted diseases and HIV • Sterilization	Covered benefit. Limitations on sterilization include: • Must be age 21 or older • Completed consent form	$0

Covered Services

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Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Hearing Care	Includes: • Basic and advanced hearing tests • Hearing aid related testing and evaluation, hearing aid, counseling, hearing aid fitting (Replacement is within three years of the initial or previous purchase) • Coverage also includes provision of hearing aid accessories (an average of sixteen (16) batteries per hearing aid in a 60 day period) replacement of parts, and repairs • Provision of a hearing aid must include a minimum of a one-year warranty at no expense to the Plan. • Exception: Payment will not be made for hearing aid batteries for residents in a Long Term Care Facility (LTC). It is the responsibility of the LTC Facility	Covered benefit. The following items or services may be provided only with prior approval: • Binaural hearing aids for adults (individuals over the age of 18) • Monaural hearing aid – creating a binaural situation for adults (individuals over the age of 18) • Hearing aid and dispensing fee – replacement is within three years of the initial or previous purchase • Exceed quantity limits in allotted time frame(s) Repair costs over $250.00 Prior authorization and referral may be required. Non-covered services include: • routine periodic exams in the absence of an identified problem • examination required for the determination of disability or incapacity • services provided in federal or state institutions • expenses associated with postage and handling for any items • travel expenses to provide testing Services must be medically necessary.	$0
Home Health Care	Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.	Covered benefit. Prior authorization and referral may be required.	$0

Covered Services

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Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Hospital – Inpatient	You are covered for an unlimited number of medically necessary days. The following services are covered, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • Blood, including storage, blood components and administration thereof • Physician services • Post stabilization services	Covered benefit. Prior authorization and referral may be required.	$0
Hospital – Outpatient	We will cover the following medically necessary services, and maybe other services not listed that you get in the outpatient department of a hospital: • Dialysis • Emergency room use • Physical, occupational or speech therapy • Audiologists • Drugs ordered by a doctor • Blood, including storage, blood components and administration thereof • Services to prevent or diagnose problems • Therapeutic and rehabilitative services • Labs and diagnostic tests • X-rays and other radiology services	Covered benefit. Prior authorization and referral may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Immunizations (Shots)	• Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • We also cover some vaccines under our outpatient prescription drug benefit	Covered benefit. Prior authorization and referral may be required.	$0
Laboratory Services/X-rays	Medically necessary diagnostic lab services and x-rays.	Covered benefit. Prior authorization and referral may be required.	$0
Nurse Midwife Services	Services provided by a nurse midwife for pregnancy and birth.	Covered benefit. Prior authorization and referral may be required.	$0
Maternity Care	• Prenatal care (before birth) • Labor and delivery • Postpartum care (after the baby is born)	Covered benefit. Prior authorization and referral may be required.	$0
Nursing Care	Members under the age of 21 can get medically necessary in-home shift nursing and personal care services provided by a registered nurse (RN), licensed practical nurse (LPN) or Certified Nurse's Aide under the direction of a qualified home health agency. Nursing Care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age 21.	Covered benefit for members under 21 who are not in the HCBS Waiver for individuals who are Medically Fragile Technology Dependent (MFTD) and have extensive medical needs that require ongoing skilled nursing care. The home health agency providing the nursing services must be in our network. Up to a maximum of 120 days for the purpose of transitioning children under age 21. Prior authorization and referral may be required.	$0
Nursing Facility Services	Facility which is duly licensed by the State which provides inpatient acute skilled nursing care, acute rehabilitation services or other related acute health services.	Covered benefit.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Organ Transplant	Bone marrow, stem cell, pediatric small bowel and liver/small bowel, heart, heart/lung, lung (single or double), liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered provided the hospital is certified by the department to perform the transplant.	Covered benefit. Prior authorization and referral may be required.	$0
Orthotics/ Prosthetics	Coverage for Prosthetic and Orthotic devices.	Covered benefit. Prior authorization and referral may be required.	$0
Palliative and Hospice Services	Services for those that are terminally ill.	Covered benefit. Prior authorization and referral may be required.	$0
PCP Visit	Visits to your Primary Care Provider	Covered benefit.	$0
Podiatric Services	Diagnosis and the medical or surgical treatment of injuries and diseases of the feet. • Routine foot care for members with certain medical conditions affecting the lower limbs.	Covered benefit. Prior authorization and referral may be required.	$0
Prescription and Over the Counter Drugs	Humana is a mandatory preferred drug plan. A preferred drug is equal to a brand name drug. Preferred drugs are the drugs that we want your provider to prescribe before brand name drugs. Over-the-counter drugs may be covered when prescribed by your provider.	Covered Benefit Prior authorization may be required Please see page 27 for additional pharmacy details, copayments, and copayment exemptions.	30 Day Supply: $2.00 Generic* $3.90 Brand* $0 Medicaid OTC
Provider Office Visits/ Preventive Care	Includes: • Periodic well adolescent visits • (members 19-20) • Well woman visits • Well man visits	Covered benefit. Prior authorization and referral may be required.	$0
Radiology	Diagnostic and therapeutic radiology services.	Covered benefit. Prior authorization and referral may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Rehabilitative Services	Including but not limited to: • Occupational therapy • Physical therapy • Speech and language therapy	Covered benefit. Prior authorization and referral may be required.	$0
Screening Assessment and Support Services (SASS)	Crisis intervention program for enrollees under 21.	Covered benefit. Under 21.	$0
Transportation Services	$0 copayment for plan approved locations up to unlimited round trip(s) per year by taxi, bus/subway, van, medical transport.	Trips allowed to pharmacies right after your doctor's visit, nursing homes and other covered services.	$0

*Some Members may be eligible for copayment exemptions, Please see page 34 for additional pharmacy details.

Covered Preventive Services

Humana Integrated Care Program of Illinois covers the following preventive services

Type of Care	Covered Services	Coverage and Benefit Limitations
Preventive Services	• Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiac (heart) rehabilitation services • Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) • Cardiovascular (heart) disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Counseling to stop smoking or tobacco use • Depression screening • Diabetes screening • Diabetic self-management training, services, and supplies • Glaucoma Test • HIV screening • Immunizations • Obesity screening and therapy to keep weight down • Prostate cancer screening exams • Routine Physical Exam • Sexually transmitted infections (STIs) screening and counseling	Covered benefit. Limitations may apply.

Service Package II.

The Health Plan shall provide, or arrange for the provision of, Service Package II, which will include all services in Service Package I and the additional services described below. Personal Assistant services in Service Package II shall be considered Covered Services only if such services can be included in a manner consistent with any existing collective bargaining agreement, or pertinent side letter, between the Illinois Department of Central Management Services and SEIU

LTSS Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Adaptive Equipment	This service includes devices, controls, or appliances, specified in the plan of care, which enable the member to increase his or her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Adult Day Services	This is a daytime community-based program for adults not living in Supported Living Facilities. Adult Day Service provides a variety of social, recreational, health, nutrition, and related support services in a protective setting. Transportation to and from the center and lunch are included as part of this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Behavioral Services	These services are behavioral therapies designed to assist members with brain injuries in managing their behavior and thinking functions, and to enhance their capacity for independent living.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Day Habilitation	This service provides members with brain injuries training with independent living skills, such as help with gaining, maintaining, or improving self-help, socialization, and adaptive skills. This service also helps the member to gain or maintain his or her maximum functional level.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Personal Emergency Response System	This electronic equipment allows members 24-hour access to help in an emergency. The equipment is connected to your phone line and calls the response center and/ or other forms of help once the help button is pressed.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Environmental Accessibility Adaptations	These are physical modifications to a member's home. The modifications must be necessary to support the health, welfare, and safety of the member and to enable the member to function with greater independence in their home. Without the modification a member would require some type of institutionalized living arrangement, such as nursing facility or assisted living. Adaptations that do not help the member's safety or independence are not included as part of this service, such as new carpeting, roof repair, central air, or home additions.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Home Delivered Meals	Prepared food brought to the member's home that may consist of a heated lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. This service is designed for the member who cannot prepare his or her own meals but is able to feed him/herself.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Home Health Aide	A person who works under the supervision of a medical professional, nurse, physical therapist, to assist the member with basic health services such as assistance with medication, nursing care, physical, occupational and speech therapy.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Homemaker	In-home caregiver hired through an agency. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming and feeding.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Nursing-Skilled	This service provides skilled nursing services to a member in their home for short-term acute healing needs, with the goal of restoring and maintaining a member's maximal level of function and health. These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required for this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	You Pay
Nursing – Intermittent	This service focuses on long term needs rather than short-term acute healing needs, such as weekly insulin syringes or medi-set set up for members unable to do this for themselves. These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required for this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Personal Assistant	In-home caregiver hired and managed by the member. The member must be able to manage different parts of being an employer such as hiring the caregiver, managing their time and timesheets, completing other employee paperwork. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming, and feeding. Personal Assistants can include other independent direct care givers such as RNs, LPNs, and Home Health Aides.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Physical, Occupational and Speech Therapy	Services designed to improve and or restore a person's functioning; includes physical therapy, occupational therapy, and/or speech therapy.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Prevocational Services	This service is for members with brain injuries and provides work experiences and training designed to assist individuals in developing skills needed for employment in the general workforce. Services include teaching concepts such as compliance, attendance, task completion, problem-solving and safety.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Respite	This service provides relief for unpaid family or primary caregivers who are meeting all the needs of the member. The respite caregiver assists the member with all daily needs when the family or primary caregiver is absent. Respite can be provided by a homemaker, personal assistant, nurse or in adult day services center.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.			
Type of Care	**Covered Services**	**Coverage and Benefit Limitations**	**You Pay**
Supported Employment	Supported employment includes activities needed to maintain paid work by individuals receiving waiver services, including supervision and training.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Supportive Living Program	An assisted living facility is a housing option that provides members with many support services to meet the member's needs to help keep the member as independent as possible. Examples of support services to meet those needs include: housekeeping, personal care, medication oversight, shopping, and social programs. Supportive Living does not offer complex medical services or supports.	Waiver eligibility required. Prior authorization and referral may be required.	$0

Excluded Services

The following services are not Covered Services:

- Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;
- Services that are provided through a Local Education Agency (LEA);
- Services that are experimental or investigational in nature;
- Services that are provided by a non-Affiliated Provider and not authorized by Health Plan, unless the Contract specifically requires that such services be Covered Services;
- Services that are provided without a required Referral or prior authorization as set forth in the provider handbook;
- Medical and surgical services that are provided solely for cosmetic purposes; and
- Diagnostic and therapeutic procedures related to infertility or sterility.

Limitations on Covered Services

The following services and benefits shall be limited as Covered Services:

- Termination of pregnancy may be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Member's medical record. Termination of pregnancy shall not be provided to Members who are eligible under the State Children's Health Insurance Program (215 ILCS 106).
- Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Member's medical record.
- If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Member's medical record.

Services Not Covered by the Health Plan

Here are some additional services that the Health Plan does not cover. These services are also not covered by Illinois Medicaid. For more information call Member Services at 1-800-764-7591.

- Experimental or research oriented procedures
- Elective Cosmetic procedures or surgery
- Infertility testing and treatment; artificial insemination
- Consultation requested by a third party or agency
- Acupuncture
- Medical examinations required for adult educational or vocational program
- Any service that you can get without charge from state and/or local health agencies
- Services that are prohibited by state or federal law
- Autopsy examinations
- Missed appointments
- Preparation of routine records, forms and reports
- Medical visits with any person that is not the patient
- Items or services that are not medically necessary
- Services provided without a required referral or prior authorization
- Elective abortion
- Medical care provided by mail or telephone, except for approved Telemedicine services
- Partial dentures for adults 20 and older
- Services from providers who are no longer in our network

Referrals

The following services are available without a referral from the Member's PCP. That means that the PCP does not have to approve these services for the Member:

- Emergency Services
- Obstetrics/gynecological services
- Behavioral Health Services
- Routine hearing exams
- Yearly eye exam and glasses
- Routine and preventive dental services
- Shots and Immunizations

Standing Referral

Members may request a standing referral be approved by the Health Plan. The Member must request the referral from their PCP or WHCP.

The Member's PCP or WHCP must consult with the provider to determine that the Member's condition requires them to receive ongoing care from a health professional other than the PCP. If a standing referral is approved, the Member will not need to get a referral for each visit to the provider on the standing referral for the referral period.

The referral period will be on the written referral. It cannot be longer than needed to provide the course of treatment listed on the referral. It cannot be longer than one (1) year from the date the standing referral is approved. It will immediately expire if the referred provider leaves the Health Plan network. The Member will be required to get a new referral from their PCP before receiving additional care.

To request a standing referral, the Member must submit to their PCP or WHCP a written request containing the following information:

- Member's name and Health Plan identification number found on their Health Plan ID card;
- Provider's diagnosis of their condition;
- Provider's recommended course of treatment;
- A statement as to the amount of time that will be required to complete the course of treatment;
- Provider's printed name, address and telephone number; and
- Participating Provider's signature.

If the Member fails to provide all above information, the Health Plan will not deny a standing referral without first trying to assist the Member in obtaining the information.

If the Health Plan approves the standing referral, the PCP will provide the Member a written referral that includes the services authorized by the standing referral, and the referral period. A PCP may renew and re-renew a standing referral.

If a standing referral is approved, the Member will be referred to a Participating Provider with whom the PCP has a referral arrangement. If no qualified Participating Provider has a referral arrangement with the Member's PCP, the PCP will provide the standing referral to a Participating Provider who doesn't have an arrangement with the PCP. If a Member wants to receive care from a Participating Provider who does not have a referral arrangement with their PCP, the Member can change their PCP.

The Member's Primary Care Provider will continue to coordinate the Member's care. The Participating Provider may not refer the Member to other health professionals. The Member must obtain additional referrals to any other health professionals from the Member's Primary Care Provider.

If a Member's request for a standing referral is denied by the Health Plan, they may appeal the Health Plan's decision through the external review process described on Page 43.

How to Get Services Approved/Authorized

Some services require a referral from the Member's PCP and prior authorization from the Health Plan before the Member can get them. The PCP will ask for this approval and schedule these services. If the Member does not get approval from their PCP, they may have to pay for the medical care or services.

Services That Require a Prior Authorization

The following services may require a prior authorization from Health Plan. For more information call Member Services at 1-800-764-7591.

- Hospital inpatient stays, including detox, rehab, Long Term Acute Care (LTAC) and behavioral health admissions
- Durable medical equipment and prosthetics
- Supplies
- Maternity care
- Radiological services
- Home health care
- Outpatient and community behavioral health based behavioral health services
- Transplant services
- Chemotherapy and radiation therapy
- Outpatient rehabilitative therapy services
- Skilled Nursing
- Chiropractic services
- Specialist care
- Podiatry services
- Outpatient Diagnostic Procedures, Tests, and Lab services, including Sleep Study services
- Outpatient Hospital services;
- Ambulatory Surgical Center services
- Outpatient Blood services
- Transportation services
- Diabetic Supplies and services
- End-Stage Renal Disease services
- Tobacco Cessation Counseling, including counseling for Pregnant Women
- Hospice
- Telehealth
- Kidney Disease Education services
- Diabetes Self-Management Training
- Certain Drugs

Behavioral Health Services

For behavioral health services, please call Member Services at 1-800-764-7591. Member Services staff can answer questions about behavioral health services and help you find a provider who can help you feel better.

Behavioral Health Care Provider

- Members can choose a Health Plan behavioral health care provider in their area by calling Member Services at 1-800-764-7591.
- No referral is needed from your PCP to get behavioral health services. If you want to change your behavioral health care provider, please call Member Services at 1-800-764-7591.
- The behavioral health care provider will make all arrangements, approvals, and referrals for behavioral health specialists and hospitals.
- For a list of providers in your area, refer to the Health Plan Medicaid Provider Directory.
- If you are unhappy with your current behavioral health care provider, you may choose another Participating Provider at no cost to you.

Behavioral Health Covered Services

Treatment for psychiatric and emotional disorders includes the following services:

- Inpatient psychiatric hospital care and crisis stabilization
- Counseling
- Evaluation and testing services
- Therapy and treatment services
- Rehabilitation services
- Day treatment services
- Substance abuse services

Primary Care Provider

Primary Care Provider (PCP)

The PCP works with the Member to coordinate all their health care. The PCP will do checkups and treat most routine health care needs. If needed, the PCP may send the Member to specialists. A Member can reach their PCP by calling his/her office. The Member's PCP's name and phone number are printed on the Health Plan ID card. It is important for a Member to call their PCP when they need medical care. The Member may also be seen by the PCP's assistant or a nurse.

Medical Home

The member's PCP will become their medical home. As a medical home, the PCP is the Member's primary source for healthcare. They will make referrals to a specialist if needed. They will also help manage the Member's chronic conditions. Members should have an ongoing, trusting relationship with their PCP. The PCP knows the Member's medical history. A medical home also includes the support team who works with the PCP to coordinate the services and care the Member needs. The goal is to help the Member be as healthy as possible.

When the Member needs to see their PCP, they should call the office for an appointment. The PCP's phone number is on the back of the Health Plan ID Card. Member Services can help a Member make their first appointment. For help in scheduling a first appointment, call Member Services at 1-800-764-7591.

It is important that Members keep appointments and get to the office on time. If the Member cannot keep an appointment, they should call the Provider's office as soon as they can. The Member can make a new appointment when they call to cancel.

Having a medical home is important because it is the first place a Member goes to get the care they need to stay healthy. This is what having a medical home means:

The Member's personal PCP gets to know them well.

The PCP works with other health care providers, such as specialists, including behavioral health providers and hospitals, to coordinate the Member's care.

- The Member's personal PCP gets to know them well.
- The PCP works with other health care providers, such as specialists, including behavioral health providers and hospitals, to coordinate the Member's care.
- The Member gets better health care because their PCP knows their health care needs.
- The Member can better understand their illnesses and how to care for yourself.
- The Member can understand how to get and take their medicine.
- The Member only uses the emergency room for health care emergencies.
- The PCP may use other team members to help the Member get better care.

PCPs may be one of the following types of health care providers.

- Family doctor
- General practitioner
- Internist
- Women's Health Care Provider (WHCP) or OB/GYN

A WHCP is a doctor, nurse practitioner or other provider who specializes in obstetrics, gynecology, or family practice. Female members may choose a WHCP as their PCP or may see a WHCP as needed and without a referral.

Members who are identified as American Indian/Alaskan Native may see providers who are designated as Indian Health Care Providers if they choose to. They are not limited to these providers and can choose any network provider. Members who are identified as American Indian/Alaskan Native will never be charged copays or coinsurance on this plan. For help in locating an Indian Health Care Provider, call Member Services at 1-800-764-7591.

In some cases, a specialist may be a PCP. If you have a specialist that you want to be your PCP, the specialist must call Health Plan. There is a process the specialists must go through to be your PCP.

Choosing Your PCP

You most likely picked your PCP when you joined Health Plan. If you did not pick your own PCP, the (ICES) gave you one. Your PCP's name and phone number are listed on your ID card. Your PCP's address will also be on your welcome letter. If this information is not listed on your ID card, call Member Services at 1-800-764-7591.

It is important to choose the PCP that is right for you. If you don't already have a PCP and you need help choosing one, call Member Services at 1-800-764-7591.

Changing Your PCP

We hope you will be happy with your PCP. But you may want to change. If you want to change your PCP for any reason, you must call Member Services at 1-800-764-7591 to let us know. We will change your PCP within 30 days of your request. We will send you a new Member ID card with your new PCP on it. The Health Plan's Member Services can also help you schedule your first appointment, if needed.

To find the PCPs you can choose from:

- Look in our Provider Directory.
- Look on our website at **www.humana.com/Medicaid**.
- Call Member Services at 1-800-764-7591.

If you need a copy of the Provider Directory, call Member Services at 1-800-764-7591.

You may not be able to change if the new PCP you want is not accepting new patients or has other restrictions. Please call us if you need help.

If a PCP tells the Health Plan that he or she is moving away, retiring or leaving the Health Plan network for any reason, we will assign another PCP for the Member. We will let the Member know by mail within 45 days whenever possible. Members can call the Health Plan for assistance in choosing a different PCP. The Health Plan will also let the Member know if any hospitals in Members your region stop accepting our plan.

Providers, including PCPs, may terminate their contract with Health Plan and may also limit the number of Members that they will accept as patients. It is possible that a specific Participating Provider or PCP will not be available to render services during the whole period of membership in the Health Plan. If Health Plan receives notice that a provider or PCP is terminating their contract or limiting Members, we will give Members 60 days advance written notice. If we receive less than sixty (60) days advance notice from the provider, the Health Plan will provide Members immediate notice that a provider's contract is terminating. You can call Humana to learn more about your health care plan, including asking for general information about Humana's financial arrangements with providers.

Access to Your PCP

Members are less than thirty (30) minutes or thirty (30) miles away from PCPs and Hospitals in urban areas and less than sixty (60) minutes or sixty (60) miles in rural areas. Members are also less than 60 minutes away from specialists.

- Members will get urgently needed care in less than twenty-four (24) hours. Urgently needed care is when a Member is very sick but his or her life is not in danger.
- Members will get routine care within three (3) weeks calling a PCP.
- Members will get routine, preventive care in less than five (5) weeks after contacting a PCP.
- Members will get initial prenatal care within two (2) weeks after contacting a provider if Member is in her first trimester. Member will be seen sooner if experiencing problems or if Member is beyond the first trimester.

Continuity of Care

New Members

Subject to certain conditions and a limited period of time of up to ninety (90) days after the effective date a new Member, who at the time of their effective date was either receiving an ongoing course of treatment or who is in her third trimester of pregnancy, has the option to request to continue to see their existing Specialty Physician. In the case of third trimester of pregnancy, this includes post-partum care directly related to delivery. Members must request approval in writing.

Existing Members

Subject to certain conditions and a limited period of time of up to ninety (90) days from the date the Health Plan notifies Member that the physician is leaving the Health Plan's network, existing members who are either receiving an ongoing course of treatment from the Participating Physician or in her third trimester of pregnancy and is receiving care from the Participating Physician, the existing Member may request to continue to see that physician. Member must make their request in writing within thirty (30) days of being notified that the physician is leaving the network.

If Member is new to Health Plan, Member must make their request in writing and an existing Member must make their request within thirty (30) days of being notified of this service.

In either case, the physician must agree to the Health Plan's Quality Improvement and Utilization Plan policies and procedures, and payment rates. The Health Plan will respond in writing within ten (10) days of receiving the Member's request with approval or the specific reason for denial of the request.

After-Hours Coverage

Except in an emergency, if a Member gets sick after a PCP's office is closed, or on a weekend, the Member should call the office anyway. An answering service will make sure the PCP gets the Member's message. The PCP will call the Member back to tell the Member what to do.

If you are having an emergency, you should ALWAYS call 911 or go to the nearest emergency room.

PCP and Other Providers

Doctors, Hospitals, pharmacies, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), Encounter Rate Clinics, and other providers in Health Plan's network can provide Members with Medically Necessary Covered Services.

Second Opinion

If the Member needs a second opinion, they should call Member Services at 1-800-764-7591. If a physician tells the Member that the Member needs surgery or any other medical need, and the Member wants a second opinion, the Health Plan will help the Member get another physician's opinion at no cost to the Member.

Our doctors will review the Member's medical history, including any test reports, and give an opinion to the PCP at no cost to the Member. After reviewing this second opinion, the PCP will make the final decision about your treatment.

If the Member wants a second opinion from a doctor who is not in the network, the Health Plan can refer the Member to that doctor.

Specialty Care

Care from a Specialist

The Member's PCP or WHCP can recommend a specialist to the Member if the Member has a specific problem. The PCP or WHCP can also recommend a lab or hospital to the Member for special services. We may need to review and approve service requests before the Member can get services. If it is medically necessary the Member can get a standing authorization to see a specialist. The specialist, lab or hospital will know how to get approval for these services.

Pharmacy

The Health Plan uses a Prescription Drug Guide (Formulary). These are the drugs that we prefer that the provider prescribe. We may also ask that the provider send us information (a prior authorization request) to explain why a specific drug or a certain amount of a drug is needed. We must approve the request before the Member can get the drug.

It is important that the Member tell the provider or dentist about prescriptions the Member is already taking. Also, the Member should tell them about nonprescription medicine or vitamin or herbal supplements the Member may be taking.

Prescription Drug Guide

The Member can find out if their medicines are on the prescription drug guide in one of two ways.

- Call Member Services at 1-800-764-7591. The Member should have a list of their prescriptions ready when calling.
- The Member should ask the representative to look up the medicines to see if they are on the list.
- Go online to **www.humana.com/Medicaid** to see the list of covered drugs.

Over the Counter Drugs

We also cover certain over the counter drugs if they are on our list. Some of these may have rules about whether they will be covered. If the rules for that drug are met, Humana Integrated Care Program of Illinois will cover the drug. Like other drugs, over the counter drugs must have a prescription from a provider for them to be covered at no cost to the Member.

The Member can find out if their over the counter drugs are on the prescription drug list by:

- Call Member Services at 1-800-764-7591. Have a list of their over the counter drugs ready when calling. Ask the representative to look up the medicines to see if they are on the list.
- Go to **www.humana.com/Medicaid** to see the list of covered over the counter drugs.

Over the Counter Item Allowance

You will have up to a $30.00 benefit per month for certain Over the Counter medications. See list of items available on pages (28-33).

For more information, call Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591.

Over-the-Counter (OTC) Health and Wellness Product Catalog

Note: You will receive the generic equivalent of all items

Antacid, Anti-Diarrheals, and Laxatives

Product code	Product name	Compare to	Package count	Price
075	Antacid/Anti-Gas Chew+	Maalox® Plus	100	$7.00
032	Antacid/Anti-Gas Liquid+	Maalox®	360 ml	$9.00
029	Anti-Diarrheal Tablets- Loperamide 2 mg+	Imodium® A-D	12	$4.75
031	Anti-Hemorrhoidal Ointment	Preparation H®	60 gm	$7.00
227	Calcium Carbonate Antacid- Extra Strength+	Tums® Extra Strength	96	$5.25
203	Calcium Carbonate Antacid- Regular Strength+	Tums® Regular Strength	150	$5.25
098	Extra Strength Gas Relief Tablets	Gas-X® Extra Strength	30	$5.75
261	Famotidine 20 mg+	Pepcid® 20 mg	25	$7.50
208	Fiber Laxative Tablets+	FiberCon®	90	$9.00
234	Glycerin Suppositories, Adult+	Fleet® Glycerin Suppositories	25	$5.25
216	Hemorrhoidal Suppositories	Preparation H® Suppositories	12	$6.00
262	Lansoprazole 15 mg	Prevacid® 15 mg	14	$10.00
093	Biscodyl 5 mg+	Dulcolax®	25	$5.00
033	Milk of Magnesia - Laxative/Antacid+	Phillips® Milk of Magnesia	360 ml	$5.25
263	Nexium® 24HR	Nexium® 24HR	14	$13.00
112	Omeprazole 20 mg+	Prilosec OTC® 20 mg	14	$11.00
115	Pink Bismuth- Chewable Tablets+	Pepto-Bismol® Chewable Tablets	30	$6.00
264	Polyethylene Glycol 3350	MiraLAX®	238 gm	$10.50
258	Psyllium Fiber Laxative Capsules+	Metamucil® Capsules	160	$11.00
104	Ranitidine 75 mg Tablets- Antacid+	Zantac® 75 mg Tablets	30	$7.00
233	Senna Laxative Tablets+	Senokot®	100	$10.00
101	Stool Softener Capsules+	Colace®	100	$7.00

Cough, Cold and Allergy

Product code	Product name	Compare to	Package count	Price
292	Fluticasone Allergy Nasal Spray	Flonase®	.34 fl oz	$14.00
113	Cetirizine 10 mg	Zyrtec® 10 mg	30	$12.00
290	Children's Allergy Liquid 5 mg/ 5 ml+	Children's Claritin®	4 oz	$9.00
260	Cough and Cold High Blood Pressure Tablets	Coricidin® HBP Cough and Cold	16	$5.25
237	Daytime PE Tablets	DayQuil™	16	$6.00
111	Expectorant- Guaifenesin 400 mg	Mucus Relief 400 mg	30	$11.00

291	Eye Itch Relief 0.025% Eye Drops	Zaditor®	.17 fl oz	$14.00
249	Fexofenadine 180 mg 24 hour	Allegra® Allergy 180 mg	30	$17.00
028	Cough Formula Expectorant	Robitussin®	120 ml	$5.00
210	Cough Suppressant/Expectorant (sugar free)	Robitussin® Sugar Free DM	118 ml	$7.00
026	Cough Suppressant/Expectorant	Robitussin® DM	120 ml	$6.00
096	Cough Suppressant/Nasal Decongestant/Expectorant	Robitussin® CF	120 ml	$5.25
110	Loratadine 10 mg	Claritin®	30	$10.00
043	Medicated Chest Rub	Vicks VapoRub®	99 gm	$6.00
117	Menthol/Benzocaine Sore Throat Lozenges	Chloraseptic® Lozenges	18	$5.50
293	Triamcinolone Allergy Nasal Spray	Nasacort® Allergy 24 hour	.57 fl oz	$17.75
228	Nasal Decongestant PE Max Strength	Sudafed® PE Tablets	36	$6.00
095	Nasal Decongestant Spray+	Afrin®	30 ml	$5.00
220	Phenol/Oral Anesthetic Sore Throat Spray	Chloraseptic®	180 ml	$6.00
099	Saline Nasal Spray+	Ocean® Saline Nasal Spray	45 ml	$5.00
097	Sinus-Acetaminophen/ Phenylephrine	Tylenol® Sinus	24	$6.00

Diabetes Management

Product code	Product name	Compare to	Package count	Price
265	Compression Stockings 15-20mmHg Regular Beige Size A (Ankle: 7”- 7 7/8”; Calf: 10”- 13”)	JOBST®	1	$15.00
266	Compression Stockings 15-20mmHg Regular Beige Size B (Ankle: 8”- 8 7/8”; Calf: 12”- 15”)	JOBST®	1	$15.00
267	Compression Stockings 15-20mmHg Regular Beige Size C (Ankle: 9”- 9 7/8”; Calf: 14”- 17”)	JOBST®	1	$15.00
268	Compression Stockings 15-20mmHg Regular Beige Size D (Ankle: 10”- 10 7/8”; Calf: 16”- 19”)	JOBST®	1	$15.00
269	Compression Stockings 15-20mmHg Regular Beige Size E (Ankle: 11”- 11 7/8”; Calf: 18”- 21”)	JOBST®	1	$15.00
270	Compression Stockings 15-20mmHg Regular Beige Size F (Ankle: 12”- 12 7/8”; Calf: 20”- 23”)	JOBST®	1	$15.00
271	Compression Stockings 15-20mmHg Regular Beige Size G (Ankle: 13”- 13 7/8”; Calf: 22”- 26”)	JOBST®	1	$15.00

272	Diabetic Skin Relief Foot Cream	Gold Bond® Diabetic Skin Relief Foot Cream	96 gm	$9.00
305	Glucose Tablets+	DEX4® Glucose Tablets	60	$11.50
273	Reagent Strips for Urinalysis	Diastix® Reagent Strips for Urinalysis	50	$11.00
274	Sharps Container	BD™ Home Sharps Container	1	$5.75
275	Test Strips for Urinalysis	Ketone Test Strips for Urinalysis	50	$11.00

First Aid

Product code	Product name	Compare to	Package count	Price
035	Alcohol Prep Pads	Curad® Alcohol Swabs	100	$6.00
226	Elastic bandage	Ace® Bandage	1	$6.00
232	First Aid Tape	J&J®	1	$4.50
044	Plastic Bandages	Band-Aids®	100	$5.25
040	Triple Antibiotic Ointment+	Neosporin®	30 gm	$6.00
231	Triple Antibiotic Ointment Plus+	Neosporin® + Pain Relief	30 gm	$7.00

Pain Relievers

Product code	Product name	Compare to	Package count	Price
294	Acetaminophen 325 mg+	Tylenol® Regular Strength	100	$7.00
002	Acetaminophen 500 mg	Tylenol® Extra Strength	100	$6.00
020	Acetaminophen 80 mg chewable	Tylenol® Children's Chewable	30	$5.00
047	Aspirin 325 mg	Bayer® 325 mg	100	$5.00
016	Aspirin Low Dose 81 mg EC	Bayer® Adult Low Strength EC	120	$6.00
287	Chewable Aspirin 81 mg+	Bayer® 81 mg Chewable	108	$5.50
213	Cold and Hot Patches	Icy Hot® Patch	5	$7.00
215	Effervescent Pain Relief	Alka-Seltzer®	36	$6.25
229	Enteric Aspirin 325 mg	Ecotrin®	100	$6.00
125	Headache Formula- Aspirin/Acetaminophen/Caffeine	Excedrin®	100	$7.00
019	Ibuprofen 200 mg Tablets	Advil® Tablets	50	$5.00
094	Ibuprofen Suspension	Motrin® Suspension	120 ml	$6.75
046	Muscle Rub	BenGay®	120 gm	$7.00
283	Naproxen Sodium 220 mg+	Aleve®	100	$9.00
230	Therapeutic Mineral Ice Gel	Mineral Ice®	227 gm	$8.00
119	Topical Analgesic- Capsaicin Cream 0.025%	Zostrix® Cream	60 gm	$8.00

Personal Care

Product code	Product name	Compare to	Package count	Price
257	7-Day Pill Box	7-Day Pill Box	1	$7.00
256	Absorbent Underpads (Disposable Chux Pads) 23”x36”	Protection Plus® Disposable Under-pads 23”x36”	20	$20.00
253	Adult Incontinence Underwear Large	Protection Plus® Classic Protective Underwear Large 40”-56”	18	$20.00
252	Adult Incontinence Underwear Medium	Protection Plus® Classic Protective Underwear Medium 28”-40”	20	$20.00
251	Adult Incontinence Underwear Small	Protection Plus® Classic Protective Underwear Small 20”-28”	22	$20.00
254	Adult Incontinence Underwear X-Large	Protection Plus® Classic Protective Underwear X-Large 56”-68”	14	$20.00
255	Adult Incontinence Underwear XX-Large	Protection Plus® Classic Protective Underwear XX-Large 68”-80”	12	$20.00
243	Bladder control pads (regular)	Poise® Moderate Pads	20	$9.00
242	Blood Pressure Home Kit (manual pump w/stethoscope)	Blood Pressure Home Kit (manual pump w/stethoscope)	1	$17.00
036	Cotton Swabs	Q-Tips®	300	$4.75
224	Dental Floss	Dental Floss	1	$4.75
225	Denture Adhesive	Fixodent®	42 gm	$6.00
307	Diaper Rash Ointment	Desitin® Ointment	60 gm	$4.50
247	Digital Bathroom Scale**	Digital Bathroom Scale	1	$35.00
245	Digital Blood Pressure Monitor	Digital Blood Pressure Monitor	1	$50.00
118	Earwax Removal Drops+	Debrox® Earwax Removal Drops	15 ml	$8.00
235	Effervescent Denture Tabs	Efferdent®	40	$5.25
244	Electric Heating Pad	Sunbeam® Electric Heating Pad	1	$40.00
276	Eye Drop Cup with Guide	Eye Drop Cup with Guide	1	$6.00
219	Eye Drops- Redness Reliever	Visine® Original	15 ml	$5.00
114	Lubricant Eye Drops (Sterile)+	Liquifilm Tears®	15 ml	$6.00
295	Oral Pain Relief- Benzocaine 20%	Orajel™ Maximum	0.5 oz	$6.75
048	Oral Thermometer	B-D® Oral Thermometer	1	$6.00
306	Sunblock SPF 30	Coppertone® SPF 30	240 ml	$8.00
284	Toothbrush	Toothbrush	3	$5.75
285	Toothpaste	Toothpaste	2	$8.00
296	Wart Remover Liquid 17%+	Compound W® Max Strength	.31 oz	$8.50

**plan limit 1 per calendar year

Skin Care

Product code	Product name	Compare to	Package count	Price
217	Allergy Cream- Itch and Pain Relief	Benadryl® Extra Strength Cream	30 gm	$5.00
037	Calamine Lotion	Caladryl®	180 ml	$5.25
038	Clotrimazole Cream 1%+	Lotrimin AF®	15 gm	$6.00
004	Hydrocortisone Cream 1%+	Cortizone 10®	30 gm	$5.00
241	Medicated Callus Remover	Dr. Scholl's®	6	$5.00
286	Medicated Lip Balm	ChapStick®	3	$5.00
277	Terbinafine Cream+	Lamisil AT®	.53 oz	$10.00
218	Tolnaftate 1% Antifungal	Tinactin® Cream	30 gm	$8.00

Smoking Cessation

Product code	Product name	Compare to	Package count	Price
123	Stop Smoking Gum- 2 mg+	Nicorette® 2 mg gum	50	$20.00
124	Stop Smoking Gum- 4 mg+	Nicorette® 4 mg gum	50	$20.00

Vitamins, Minerals and Supplements*

Product code	Product name	Compare to	Package count	Price
297	Antioxidant Tablets+	Antioxidant Tablets	60	$7.00
109	Calcium Citrate + Vitamin D	Citracal® Caplets + D	60	$7.00
248	Chewable Calcium with Vitamin D	Caltrate® 600 + D Plus Minerals Chewable	60	$9.00
902	Co-Enzyme Q-10 30 mg	Co-Enzyme Q-10 30 mg	30	$10.00
063	Complete Senior Vitamins and Minerals	Centrum® Silver	60	$10.00
011	Daily Multivitamin and Mineral	Centrum®	130	$8.00
907	Eye Care Vitamins	Ocuvite® Lutein	36	$9.00
298	Ferrous Sulfate 5 gr+	Feosol® 100	100	$8.50
240	Folic Acid 800 mcg+	Folic Acid 800 mcg	100	$5.00
299	Gummy Multi-Vitamin	Gummy Multi-Vitamin	120	$10.00
300	Gummy Vitamin C 250 mg	Gummy Vitamin C 250 mg	100	$10.00
301	Gummy Vitamin D 2000 IU	Gummy Vitamin D 2000 IU	120	$10.00
302	Magnesium Oxide 400 mg+	Mag-Ox® 400 mg	120	$10.00
278	Melatonin 5 mg	Melatonin 5 mg	100	$6.50
107	One a Day Women's Multivitamin	One-A-Day Women's®	60	$7.00
015	Oyster Calcium + Vitamin D	Os-Cal® 500+D	60	$6.00
303	Potassium Gluconate 595 mg	Potassium Gluconate 595 mg	100	$5.50
909	Timed Release Niacin 500 mg+	Timed Release Niacin 500 mg	100	$8.00

238	Vitamin B-12 1000 mcg	Vitamin B-12 1000 mcg	100	$7.00
279	Vitamin B-12 5000 mcg Sublingual	Vitamin B-12 5000 mcg Sublingual	30	$8.00
280	Vitamin B-Complex Sublingual	Vitamin B-Complex Sublingual	60	$7.00
903	Vitamin B-Complex with B-12	Vitamin B-Complex with B-12	100	$8.00
010	Vitamin C 500 mg	Vitamin C 500 mg	100	$6.00
209	Vitamin D 1000 IU	Vitamin D 1000 IU	100	$7.00
239	Vitamin D 5000 IU	Vitamin D 5000 IU	100	$9.00
012	Vitamin E 400 IU Synthetic+	Vitamin E 400 IU Synthetic	100	$7.00

* For items noted above: Prior to purchase the enrollee must have appropriate conversations with the enrollee's personal provider and the enrollee's personal provider must orally recommend the OTC item.

Women's Health

Product code	Product name	Compare to	Package count	Price
041	Clotrimazole 1% Vaginal Cream+	Gyne-Lotrimin® Cream	45 gm	$8.00
304	Miconazole 3 Combo Pack+	Monistat® 3 Combo Pack	3 Day Supply	$13.00

+This item is also covered on the plan's preferred drug list at $0 with a prescription from your provider, or you can order on your $30 OTC benefit without a prescription.

Notes for frequently used products

How to Get Prescriptions

Here is how to get prescriptions as a Health Plan member:

- If the Member needs medicine, the provider will choose a drug from Health Plan's list of prescription drugs.
- The provider will write a prescription. Ask the provider to make sure that the medicine is on the list.
- Take the prescription to a network pharmacy to have it filled.
- Show the Health Plan Member ID card at the pharmacy. As long as the Member shows their member ID card and uses medicines from the prescription drug list, generic drugs will cost $2.00 co-pay and brand name drugs will cost $3.90 co-pay for a one month supply. There is no co-pay for Medicaid over the counter (OTC) drugs.
- Prescriptions may be available in up to 90 day supplies for some medications.

Pharmacy Copayment Exemptions

Members listed below or who meet the following are exempt from pharmacy copayments:

- Institutionalized participants
- Pregnant women
- American Indians /Alaskan Natives
- Hospice patients
- Services provided to eligible participants living in residential care facilities. Examples could include Supportive Living Facilities (SLFs) and Community Integrated Living Arrangements (CILAs).
- Insulin
- Compound drugs
- Family planning services and drugs

How to find a Network Pharmacy

The Member can find a network pharmacy by:

- Checking the provider directory.
- Calling Member Services at 1-800-764-7591. Ask the representative to help find a network pharmacy in their area.
- Going online to our website at **www.humana.com/Medicaid** to search for a pharmacy in their area.
- All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies that are not in the Health Plan network may not be covered.

Mail Order Prescriptions

If the Member takes medicine for an ongoing health condition, they can have medicines mailed to their home. Health Plan works with companies like Humana Pharmacy® to provide this service which the Member can get at no additional cost to the Member.

If the Member chooses to use a mail order pharmacy, the medicine comes right to their door. The Member can schedule refills and reach pharmacists if the Member has questions. Here are some other features of mail delivery.

- Pharmacists check each order for safety.
- The Member can order refills by mail, by phone, online, or the Member can sign up for automatic refills.

The Member can sign up for a mail order pharmacy in one of three ways.

- Call Member Services at 1-800-764-7591.
- Go to www.HumanaPharmacy.com. Then log in and sign up for Mail Delivery. If the Member says it's okay, Humana Pharmacy® will call their provider to get a prescription.
- Ask the provider to write a prescription for a 30 or 90 day supply with up to one year of refills. The provider can send your prescription directly to Humana Pharmacy® or other mail order pharmacies to be filled.

If Medicines Are Not on the Prescription Drug Guide

If the medicine is not on the prescription drug guide, there are some things the Member can do:

- Ask for a temporary supply of the drug. Only members in certain situations can get a temporary supply. This will give the Member and the provider time to change to another drug or to file a request to have the drug covered.
- Ask the provider for a similar drug that is on the list.
- Ask the provider to ask Health Plan for an exception. The provider will know how to do this.

Medical Care

Where to Get Medical Care

We want to make sure Members get the right care from the right health care provider when they need it. Use the information below to help you decide where you should go for medical care.

How to Decide whether to go to an ER, Urgent Care or PCP

Ask yourself these questions:

- Is it safe to wait?
- Is it safe to wait and call my doctor first?
- Is it safe to wait and schedule an appointment in the next day or two with my doctor?
- Is it safe to wait if I can get an appointment today with my doctor?
- If my doctor can't see me, is it safe to wait to be seen at an urgent care clinic as a walk-in?
- Could I die or suffer a serious injury if I don't get medical help right away?

If you are not sure if your illness or injury is an emergency, call your doctor. Or call our 24-hour nurse advice line. Just dial 1-855-235-7494 to talk to a nurse. For a list of facilities providing emergency and post-stabilization services, please refer to the Health Plan Medicaid Provider Directory or call Member Services at 1-800-764-7591.

PCP Services

You should see your PCP for all routine visits. Here are some examples of conditions that can be treated by your PCP:

- Dizziness

- High/low blood pressure
- Swelling of the legs and feet
- High/low blood sugar
- Persistent cough
- Loss of appetite
- Restlessness
- Joint pains
- Colds/flu
- Headache
- Earache
- Backache
- Constipation
- Rash
- Sore throat
- Taking out stitches
- Vaginal discharge
- Pregnancy tests
- Pain management

Urgent Care

Urgent care is when you need care right away, but you are not in danger of lasting harm or of losing your life. Here are some examples of urgent care:

- Sore throat
- Flu
- Migraines

You can visit an urgent care center for non-emergency situations to keep an injury or illness from getting worse. You can do this when your PCP's office is closed or if your PCP is not able to see you right away.

If you think you need urgent care, you can:

- Call your PCP for advice. You can reach your PCP or a back-up doctor, 24 hours a day, 7 days a week.

OR

- Call our 24-hour nurse advice line at 1-855-235-7494.

OR

- Go to a participating urgent care center. They are listed in the Provider Directory. Or you can find them on our website at **www.humana.com/Medicaid**. After you go, always call your PCP to schedule follow-up care.

Sometimes Members get sick or injured while traveling. If a member needs to go to an urgent care center while out of our service area, they should call their PCP. Or call our 24-hour nurse advice line. The number is 1-855-235-7494. They can help you decide what to do. If you go to an urgent care center, call your PCP as soon as you can. Let him or her know of your visit.

Emergency Services

Emergency services are for a medical problem that a Member thinks is so serious that it must be treated right away by a doctor.

We cover care for emergencies both in and out of our service area. You have the right to use any hospital or other setting for emergency services. Here are some examples of when emergency services are needed:

- Miscarriage/pregnancy with vaginal bleeding
- Severe chest pain
- Shortness of breath
- Loss of consciousness
- Seizures/convulsions
- Uncontrolled bleeding
- Severe vomiting
- Rape
- Major burns
- Feeling like you are going to harm yourself or someone else

You do not have to contact us for an okay before you get emergency services. If you have an emergency, call **911** or go to the nearest ER. If there is no 911 service in your area, call the nearest ambulance service. If you are not sure what to do, call your PCP for help. Or you can call our 24-hour nurse advice line at 1-855-235-7494.

Remember, if you have an emergency:

- Go to the nearest ER. Be sure to tell them that you are a member of our plan. Show them your ID card.
- If the provider that treats you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused it, the provider must call Health Plan.
- If you are able, call your PCP as soon as you can. Let him or her know that you have a medical emergency. Or you can have someone call for you. Then call your PCP as soon as you can after the emergency to schedule any follow-up care.
- If the hospital has you stay, please make sure that Health Plan is called within 24 hours.

Post Stabilization Care

This is care a Member gets after they have received emergency medical services. It helps maintain, improve or clear up their health issue. It does not matter whether the Member gets the emergency care in or outside of our network. These services may be provided in the hospital or in an office setting. We will cover services to make sure the Member is stable after an emergency. The Member should get care until their condition is stable.

Hospital Care

If a Member needs hospital care, their PCP will make arrangements for them. The Member may have an emergency and be admitted by a hospital doctor. If this happens, the Member should call their PCP as soon as possible. Or have a friend or family member call for them.

Emergency and Non-emergency Transportation

- For emergency transportation services, call 911.
- If a Member needs a ride to a health care appointment that is not an emergency or to the pharmacy right after a doctor's visit, they can call MTM, Inc. at 1-855-253-6865 (TTY 711) Monday – Friday 8:00 am – 8:00 pm Central Time, or online at http://memberportal.net/.

Out-of-Network Non-emergency Care Outside the Service Area

If a Member is away from home and has an emergency, they should go to the nearest emergency room. The Member should call PCP as soon as they can. Only emergency services are covered outside the Member's service area. The Health Plan is not responsible for non-emergency health care services received from an out-of-network provider unless the Health Plan approves these services.

Out-of-Network Care for Services not Available

The Member's PCP will arrange for out-of-network care if the Health Plan is unable to provide them with necessary covered services or a second opinion if a network provider is not available. The Health Plan will ensure that there is no cost to you.

Grievances and Appeals

We want you to be happy with services you get from Humana Integrated Care Program of Illinois and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item.

Humana Integrated Care Program of Illinois takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. Humana Integrated Care Program of Illinois has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

These are examples of when you might want to file a grievance.

- Your provider or a Health Plan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a Health Plan staff member was rude to you.
- Your provider or a Health Plan staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591. You can also file your grievance in writing via mail or fax at:

Humana Integrated Care Program of Illinois
Attn: Grievance and Appeals
Dept. P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Humana Integrated Care Program of Illinois Services at 1-800-764-7591 for assistance.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing impaired, call the Illinois Relay at 711.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Humana Integrated Care Program of Illinois in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

Appeals

You may not agree with a decision or an action made by Humana Integrated Care Program of Illinois about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" letter from us. This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services

Here are two ways to file an appeal.

- Call Member Services at 1-800-764-7591. If you file an appeal over the phone, you must follow it with a written signed appeal request.
- Mail or fax your written appeal request to:

Humana Integrated Care Program of Illinois
Attn: Grievance and Appeals
Dept. P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220 (for expedited appeals only)

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your appeal. If you are hearing impaired, call the Illinois Relay at 711.

Can someone help you with the appeal process?

You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your Primary Care Physician or a family member, for example.
- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at 1-800-641-3929 (Voice) or 1-888-460-5111 (TTY).

To appoint someone to represent you, either: 1) Send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) Fill out the Authorized Representative Appeals form. You may find this form on our website at: https://www.humana.com/individual-and-family-support/tools/member-forms.

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

Humana Integrated Care Program of Illinois will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Humana Integrated Care Program of Illinois may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Decision Notice. The Decision Notice will tell you what we will do and why.

If Humana Integrated Care Program of Illinois decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Humana Integrated Care Program of Illinois decision does not agree with the Notice of Action, we will approve the services to start right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Humana Integrated Care Program of Illinois reviews your appeal.

How can you expedite your Appeal?

If you or your provider believes our standard timeframe of fifteen (15) business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, information about your case and why you are asking for the expedited appeal. We will let you know within twenty-four (24) hours if we need more information. Once all information is provided, we will call you within twenty-four (24) hours to inform you of our decision and will also send you and your authorized representative the Decision Notice.

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Humana Integrated Care Program of Illinois will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591.

What happens next?

After you receive the Humana Integrated Care Program of Illinois appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/ or asking for an External Review of your appeal within **thirty (30) calendar days** of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within **thirty (30) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Humana Integrated Care Program of Illinois Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

You can ask for a State Fair Hearing in one of the following ways:

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-2005
Email: HFS.FairHearings@illinois.gov

Or you may call (855) 418-4421, TTY: (800) 526-5812

- If you want to file a State Fair Hearing related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Appeal Waiver services, or any Home Services Program (HSP) service, send your request in writing to:

Illinois Department of Human Services Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-8573
Email: DHS.HSPAppeals@illinois.gov

Or you may call (800) 435-0774, TTY: (877) 734-7429

State Fair Hearing Process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully.

At least three (3) business days before the hearing, you will receive information from Humana Integrated Care Program of Illinois. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to Humana Integrated Care Program of Illinois and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

You will need to notify the appropriate Hearings Office of any accommodation you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

Continuance or Postponement

You may request a continuance during the hearing, or a postponement prior to the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, you and all parties to the appeal will be notified in writing of a new date, time and place. The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within **ten (10) calendar days** from the date you received the Dismissal Notice, if the reason for your failure to appear was:

- A death in the family
- Personal injury or illness which reasonably would prohibit your appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or your authorized representative a letter rescheduling the hearing with copies to all parties to the appeal.

If we deny your request to reset your hearing, you will receive a letter in the mail informing you of our denial.

The State Fair Hearing Decision

A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as **thirty- five (35) days** from the date of this letter. If you have questions, please call the Hearing Office.

External Review (for medical services only)

Within **thirty (30) calendar days** after the date on the Humana Integrated Care Program of Illinois appeal Decision Notice, you may choose to ask for a review by someone outside of Humana Integrated Care Program of Illinois. This is called an external review. The outside reviewer must meet the following requirements:

- Board certified provider with the same or like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your identity during the review

External Review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

Your letter must ask for an external review of that action and should be sent to:

Humana Integrated Care Program of Illinois
Attn: Grievance and Appeals Dept. P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have **five (5) business days** to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have **five (5) business days** from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and the Health Plan a letter with their decision within five (5) calendar days of receiving all the information they need to complete their review.

Expedited External Review

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an **expedited external review**. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at 1-800-764-7591. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Humana, Inc.
Attn: Grievance and Appeals Dept.
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Humana, Inc. know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Humana, Inc. with the decision within forty-eight (48) hours.

Report Suspected Medicaid Fraud

- Medicaid fraud and abuse are violations of state and federal law and cost millions of dollars each year.
- If you think there has been Medicaid fraud, abuse or overpayment, call Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591 (TTY: 711).
- To report possible fraud and/or abuse of Illinois Medicaid, call the Consumer Complaint Hotline toll free at 1-800-386-5438 (TTY 1-800-964-3013) (Spanish Hotline 1-866-310-8398) or fill out a Fraud Report Form online at www.state.il.us/agency/oig.
- The Office of Inspector General of HFS investigates providers who may have overbilled or defrauded Illinois' Medicaid program. It will get back overpayments, issue penalties, and refer cases of suspected fraud for criminal investigation.
- You can also report Medicaid Fraud, Abuse or Neglect by calling the Illinois Medicaid Fraud Control Unit (MFCU) at 1-888-557-9503.

Reporting Abuse, Neglect, Exploitation, or Unusual Incidents

If you are the victim of abuse, neglect or exploitation, you should report this to your Health Plan Care Coordinator right away. You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept confidential and anonymous reports are accepted.

- **Nursing Home Hotline – 1-800-252-4343**
  Illinois Department of Public Health Nursing Home Hotline is for reporting complaints regarding hospitals, nursing facilities, and home health agencies and the care or lack of care of the patients.
- **Office of the Inspector General – 1-800-368-1463**
  The Illinois Department of Human Services Office of Inspector General Hotline is to report allegations of abuse, neglect, or exploitation for people 18 to 59 years old.
- **Aging/Elder Abuse – 1-866-800-1409 (TTY – 1-888-206-1327)**
  The Illinois Department on Aging Elder Abuse Hotline is to report allegations of abuse, neglect, or exploitation for people 60 years old and over. Your Health Plan Care Coordinator will provide you with 2 brochures on reporting Elder Abuse and Exploitation. You can request new copies of these brochures at any time.

Illinois law defines abuse, neglect, and exploitation as:

- **Physical abuse** — Inflicting physical pain or injury upon a senior or person with disabilities.
- **Sexual abuse** — Touching, fondling, intercourse, or any other sexual activity with a senior or person with disabilities, when the person is unable to understand, unwilling to consent, threatened or physically forced.
- **Emotional abuse** — Verbal assaults, threats of abuse, harassment, or intimidation.
- **Confinement** — Restraining or isolating the person, other than for medical reasons.
- **Passive neglect** — The caregiver's failure to provide a senior or person with disabilities with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
- **Willful deprivation** — Willfully denying a senior or person with disabilities medication, medical care, shelter, food, a therapeutic device or other physical assistance, and thereby exposing that adult to the risk of physical, mental, or emotional harm — except when the person has expressed an intent to forego such care.
- **Financial exploitation** — The misuse or withholding of a senior or person with disabilities' resources to the disadvantage of the person or the profit or advantage of someone else

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Service at 1-800-764-7591 (TTY 711).

If you believe that Humana Inc. or its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 – 4618
1-800-764-7591, or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Customer Service 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, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-764-7591 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-764-7591 (TTY: 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-764-7591 (TTY: 711)**.

繁體中文 (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。請致電 **1-800-764-7591 (TTY: 711)**。

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-800-764-7591 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-764-7591 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-764-7591 (телетайп: 711)**.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-764-7591 (TTY: 711)**.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-764-7591 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-764-7591 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-764-7591 (ATS : 711)**.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-764-7591 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-764-7591 (TTY: 711)**.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-764-7591 (TTY: 711)**.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-764-7591 (رقم هاتف الصم والبك: 711)**.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-764-7591 (TTY: 711)** पर कॉल करें।

وذرأ (Urdu):

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-764-7591 (TTY: 711)** ۔

ILHJTASEN