2017

Annual Notice of Changes

Humana Gold Plus Integrated (Medicare-Medicaid Plan), A Commonwealth Coordinated Care Plan

Select Counties in Virginia

Humana®

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

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Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan (Medicare-Medicaid Plan) offered by Humana Health Plan, Inc.

Annual Notice of Changes for 2017

You are currently enrolled as a member of Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan. Next year, there will be some changes to the plan's benefits, coverage, rules, and costs. This Annual Notice of Changes tells you about the changes.

A. Think about Your Medicare and Medicaid Coverage for Next Year

It is important to review your coverage now to make sure it will still meet your needs next year. If it does not meet your needs, you can leave the plan at any time.

If you leave our plan, you will still be in the Medicare and Medicaid programs.

- You will have a choice about how to get your Medicare benefits (go to page 10 to see your choices).
- You will get your Medicaid benefits through any enrolled Medicaid provider (this is called "fee-for-service").

Additional Resources

- You can get this information for free in other languages. Call 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. The call is free.
- Usted puede obtener esta información gratis en otros idiomas. Llame al 1-855-280-4002 (TTY: 711). La llamada es gratuita. Estamos a su disposición de lunes a viernes, de 8 a.m. a 8 p.m., hora oficial del este. Sin embargo, tenga en cuenta que nuestro sistema telefónico automatizado puede responder a su llamada fuera del horario de atención, durante los fines de semana y feriados. Por favor, deje su nombre y número de teléfono y le volveremos a llamar antes del final del próximo día laborable. Visite **Humana.com** para acceder las 24 horas a información tal como el historial de reclamaciones, la elegibilidad y la lista de medicamentos de Humana. Ahí también puede utilizar la herramienta de búsqueda de proveedores Physician Finder y obtener noticias e información de salud.
- You can get this Annual Notice of Changes for free in other formats, such as large print, braille, or audio. Call us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free.
- You can make a standing request to get materials, now and in the future, in a language other than English or in an alternate format by calling Customer Care at the number at the bottom of the page.

About Humana Gold Plus Integrated

- Humana Gold Plus Integrated H3480-001 (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and the Virginia Department of Medical Assistance Services (Medicaid) to provide benefits of both programs to enrollees.
- Coverage under Humana Gold Plus Integrated qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual shared responsibility requirement for MEC.
- Humana Gold Plus Integrated plan is offered by Humana Health Plan, Inc. When this A*nnual Notice of Changes* says "we," "us," or "our," it means Humana Health Plan, Inc. When it says "the plan" or "our plan," it means Humana Gold Plus Integrated.

Disclaimers

Limitations, *copays,* and restrictions may apply. For more information, call Humana Gold Plus Integrated Customer Care or read the Humana Gold Plus Integrated Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Humana Gold Plus Integrated pay for your services.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits and/or copayments may change on January 1 of each year.

Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.

Important things to do:

- **Check if there are any changes to our benefits and costs that may affect you.** Are there any changes that affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in section C, page 7 for information about benefit and cost changes for our plan.
- **Check if there are any changes to our prescription drug coverage that may affect you.** Will your drugs be covered? Are they in a different cost-sharing tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in section C, page 8 for information about changes to our drug coverage.
- **Check to see if your providers and pharmacies will be in our network next year.** Are your doctors in our network? What about your pharmacy? What about the hospitals or other providers you use? Look in section B, page 6 for information about our *Provider and Pharmacy Directo*ry.
- **Think about your overall costs in the plan.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How do the total costs compare to other coverage choices?
- **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Humana Gold Plus Integrated:	**If you decide to <u>change</u> plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, you can switch plans at any time. If you enroll in a new plan, your new coverage will begin on the first day of the following month. Look in Section D, page 10 to learn more about your choices.

B. Changes to the network providers and pharmacies

Our provider and pharmacy networks have changed for 2017.

We strongly encourage you to review our current Provider and Pharmacy Directory to see if your providers or pharmacy are still in our network. An updated *Provider and Pharmacy Directory* is located on our website at **Humana.com**. You may also call Customer Care at the number at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It is important that you know that we may also make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, see Chapter 3 of your Member Handbook.

C. Changes to benefits and costs for next year

Changes to benefits and costs for medical services

We are changing our coverage for certain medical services and what you pay for these covered medical services next year. The following table describes these changes.

	2016 (this year)	2017 (next year)
Dental Services	Dental benefits are covered. Services include: • 1 comprehensive oral evaluation per year • 1 cleaning per year • 1 bitewing x-ray per year • 1 amalgam filling per year • 1 composite filling per year	Dental benefits are covered. Services include: • 1 comprehensive oral evaluation per year • 1 cleaning per year • 1 bitewing x-ray per year • 1 filling per year (amalgam or composite) • 1 panoramic x-ray per three years is covered
Health and Wellness Education Programs	Humana Active Outlook is covered. Humana Active Outlook (HAO) is a lifestyle enrichment program with great features like HAO Publications and other health and wellness educational materials.	Humana Active Outlook is not covered. The plan now offers: • Online and printed health education materials and tools • Nutrition counseling • Disease management programs
Non-Medicaid Over-the-Counter (OTC)	OTC products are covered. • Up to $35 maximum allowance per month for certain non-Medicaid covered OTC items.	OTC products are covered. • Up to $25 maximum allowance per month for certain non-Medicaid covered OTC items.
Podiatry Services	Podiatry Services are covered. • 12 additional visits per year are covered.	Podiatry Services are covered. • 6 additional visits per year are covered.

	2016 (this year)	2017 (next year)
Tobacco Cessation	Smoking Cessation with QuitNet Comprehensive is covered. Services include: • Web-based or telephonic coaching • The QuitNet, QuitGuide, and QuitTips email support • Over-the-counter nicotine replacement therapy, including patches, gums, and lozenges	Smoking Cessation with QuitNet Comprehensive is **not** covered. Services now include: • 1 additional counseling quit attempt per year as a preventive service. Each counseling attempt includes up to 4 face-to-face visits. • You are also eligible for to receive Nicotine Replacement Therapy products (gum, lozenges, and patches) through your OTC benefit.
Worldwide Emergency Services	Worldwide Emergency Services is covered.	Worldwide Emergency Services is **not** covered.

Changes to prescription drug coverage

Changes to our Drug List

We sent you a copy of our 2017 *List of Covered Drugs* in this envelope. The *List of Covered Drugs* is also called the "Drug List."

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care at the number at the bottom of the page to ask for a list of covered drugs that treat the same condition. This list can help your provider find a covered drug that might work for you.
- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. You can ask for an exception before next year and we will give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). To learn what you must do to ask for an exception, see Chapter 9 of the *2017 Member Handbook,* section 6.3, page 139 or call Customer Care at the number at the bottom of the page. If you need help asking for an exception, you can contact Customer Care or your care manager.

If you have previously been granted an exception and it is expiring, you should contact us in advance of the expiration date to have it re-authorized. The expiration date was included in your original approval letter. You can call Humana Clinical Pharmacy Review at 1-800-555-2546 (TTY: 711) Monday through Friday 8:00 a.m. to 8:00 p.m. Eastern time.

Changes to prescription drug costs There are two payment stages for your Medicare Part D prescription drug coverage under Humana Gold Plus Integrated. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: *Initial Coverage Stage*	Stage 2: *Catastrophic Coverage Stage*
During this stage, **the plan pays part of the costs** of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, the **plan pays all of the costs** of your drugs through December 31, 2017. You begin this stage when you have paid a certain amount of out-of-pocket costs.

Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

We moved some of the drugs on the Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To see if your drugs will be in a different tier, look them up in the Drug List.

The table below shows your costs for drugs in each of our 4 drug tiers. These amounts apply only during the time when you are in the Initial Coverage Stage.

	2016 (this year)	2017 (next year)
Drugs in Tier 1 *(Generic drugs)* Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 up to $2.95 per prescription.	Your copay for a one-month (30-day) supply is $0 up to $3.30 per prescription.
Drugs in Tier 2 *(Brand drugs)* Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 up to $7.40 per prescription.	Your copay for a one-month (30-day) supply is $0 up to $8.25 per prescription.
Drugs in Tier 3 (Non-Medicare Rx Drugs) Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 per prescription.	Your copay for a one-month (30-day) supply is $0 per prescription.
Drugs in Tier 4 (Non-Medicare OTC) Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 per prescription.	Your copay for a one-month (30-day) supply is $0 per prescription.

The Initial Coverage Stage ends when your total out-of-pocket costs reach $4,950. At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year.

D. Deciding which plan to choose

If you want to stay in Humana Gold Plus Integrated

We hope to keep you as a member next year.

To stay in our plan you don't need to do anything. If you do not sign up for a different Medicare-Medicaid Plan, change to a Medicare Advantage Plan, or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2017.

If you want to change plans

You can end your membership at any time without penalty. If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan. If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Humana Gold Plus Integrated, you will go back to getting your Medicare and Medicaid services separately.

These are the four ways people usually end membership in our plan:

1. You can change to: **A different Medicare-Medicaid Plan**	**Here is what to do:** Enroll in the new Medicare-Medicaid Plan by calling state enrollment broker at 1-855-889-5243, Monday - Friday 8:30 a.m. - 6 p.m. Eastern time. TTY users should call 1-800-817-6608. You will automatically be disenrolled from Humana Gold Plus Integrated when your new Medicare-Medicaid Plan's coverage begins.
2. You can change to: **A Medicare health plan (such as a Medicare Advantage Plan)**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your new Medicare Advantage Plan's coverage begins. You will get your Medicaid benefits separately through fee-for-service.

3. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your Original Medicare coverage begins. You will get your Medicaid benefits separately through fee-for-service.
4. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your Original Medicare coverage begins. You will get your Medicaid benefits separately through fee-for-service.

E. Getting help

Getting help from Humana Gold Plus Integrated

Questions? We're here to help. Please call Customer Care at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. Calls to these numbers are free.

Read your 2017 Member Handbook

The *2017 Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits and costs. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

An up-to-date copy of the *2017 Member Handbook* is always available on our website at **Humana.com**. You may also call Customer Care at 1-855-280-4002 (TTY: 711) to ask us to mail you a *2017 Member Handbook*.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

Visit our website

You can also visit our website at **Humana.com**. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

Getting help from the state enrollment broker

The state enrollment broker can help you enroll in a health plan, answer questions about benefits, and help you with any problems. You can call the state enrollment broker at 1-855-889-5243, Monday - Friday 8:30 a.m. - 6 p.m. Eastern time. TTY users should call 1-800-817-6608.

Getting help from the Commonwealth Coordinated Care Ombudsman

The Commonwealth Coordinated Care Ombudsman can help you if you are having a problem with Humana Gold Plus Integrated. The Ombudsman is not connected with us or with any insurance company or health plan. The phone number for the Commonwealth Coordinated Care Ombudsman is 1-800-552-5019 (TTY: 1-800-464-9950).The services are free.

Getting help from the State Health Insurance Assistance Program (SHIP)

You can also call the State Health Insurance Assistance Program (SHIP). The SHIP counselors can help you understand your Medicare-Medicaid Plan choices and answer questions about switching plans. The SHIP is not connected with us or with any insurance company or health plan. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP). The phone number for VICAP is 1-800-552-3402.

Getting help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227).

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). If you choose to disenroll from your Medicare-Medicaid Plan and enroll in a Medicare Advantage plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare Medicare Advantage plans.

You can find information about Medicare Advantage plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans.”)

Read *Medicare & You 2017*

You can read *Medicare & You 2017* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare.

If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Getting help from Medicaid

If you have questions about the help you get from Medicaid, you can contact the Department of Medical Assistance Services (DMAS):

- Call 804-786-6145 from 8:00 a.m. to 5:00 p.m. TTY users should call 1-800-343-0634.
- Visit the DMAS website at http://www.dmas.virginia.gov.

2017

Member Handbook

Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan

Select Counties in Virginia

Humana®

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

H3480_ANOCMH_2017A_Approved

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Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan Member Handbook

January 1, 2017 –December 31, 2017

Your Health and Drug Coverage under the Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan

This handbook tells you about your coverage under Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan through December 31, 2017. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing facility or hospital. **This is an important legal document. Please keep it in a safe place.**

This Humana Gold Plus Integrated plan is offered by Humana Health Plan, Inc. When this *Member Handbook* says "we," "us," or "our," it means Humana Health Plan, Inc. When it says "the plan" or "our plan," it means Humana Gold Plus Integrated.

You can get this handbook for free in other languages. Call 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. The call is free.

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A. Welcome to Humana Gold Plus Integrated

Humana Gold Plus Integrated is a Medicare-Medicaid Plan in the Commonwealth Coordinated Care (CCC) Program. A *Medicare-Medicaid plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care managers and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Humana Gold Plus Integrated was approved by the State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the CCC Program.

The CCC Program is a demonstration program jointly run by the Commonwealth of Virginia and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

B. What are Medicare and Medicaid?

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS).

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Virginia must approve Humana Gold Plus Integrated each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, and
- Medicare and the State approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services would not be affected.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medicaid services from Humana Gold Plus Integrated, including prescription drugs. You do not pay extra to join this health plan.

Humana Gold Plus Integrated will help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care manager. This is a person who works with you, with Humana Gold Plus Integrated, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care manager.
- The care team and care manager will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - Your care team will make sure your test results are shared with all your doctors and other providers.

D. What is Humana Gold Plus Integrated service area?

Our service area includes these cities and counties in Virginia: Albemarle, Alexandria City, Alleghany, Amelia, Arlington, Augusta, Bath, Bedford, Bedford City, Botetourt, Brunswick, Buckingham, Buena Vista City, Caroline, Charles City, Charlottesville City, Chesapeake City, Chesterfield, Colonial Heights City, Covington City, Craig, Culpeper, Cumberland, Dinwiddie, Emporia City, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Fredericksburg City, Giles, Gloucester, Goochland, Greene, Greensville, Hampton City, Hanover, Harrisonburg City, Henrico, Henry, Highland, Hopewell City, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lexington City, Loudoun, Louisa, Lunenburg, Madison, Manassas City, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Nottoway, Orange, Patrick, Petersburg City, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford City, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Salem City, Southampton, Spotsylvania, Stafford, Staunton City, Suffolk City, Surry, Sussex, Virginia Beach City, Waynesboro, Westmoreland, Williamsburg City, Wythe, and York.

Only people who live in our service area can get Humana Gold Plus Integrated.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan member?

You are eligible for our plan as long as:

- you live in our service area, ***and***
- you are eligible for Medicare Part A and enrolled in Medicare Parts B, ***and***
- you are eligible for Medicaid, ***and***
- you are a United States citizen or are lawfully present in the United States, ***and***
- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- you are receiving full Medicaid, and you are age 21 years and older at the time of enrollment. This includes individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities (NF).

F. What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment within the first 30-60 days depending upon the type of services you require.

The health risk assessment helps us understand your medical needs. We will attempt to contact you by phone first. If we cannot reach you by phone, we mail a letter and the HRA to you. We will send you a postage paid return envelope to send it back. If we do not get a response, we will attempt to contact you at your home. If you need help completing the form, we can call you or meet face-to-face. If you need help, call Customer Care at the number at the bottom of the page. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

If Humana Gold Plus Integrated is new for you, you can keep seeing the doctors you go to now for 180 days after you first enroll. You can also keep getting your prior authorized services for the duration of the prior authorization or for 180 days after you first enroll, whichever is sooner. If you are in a nursing facility at the start of the CCC Program, you may remain in the facility as long as you continue to meet the criteria for nursing facility care, unless you or your family prefers to move to a different nursing facility or return to the community. Nursing home criteria are established by the Virginia Department of Medical Assistance Services.

After 180 days in our plan, you will need to see doctors and other providers in the Humana Gold Plus Integrated network. *A network provider is a provider who works with the health plan*. See Chapter 3, Section B, page 26 for more information on getting care.

G. What is a care plan?

A *care plan* is the plan for what health services you will get and how you will get them.

After your health risk assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Every year, your care team will work with you to update your care plan when the health services you need and want change.

H. Does Humana Gold Plus Integrated have a monthly plan premium?

No.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, Section 4, page 124 or call 1-800-MEDICARE (1-800-633-4227).

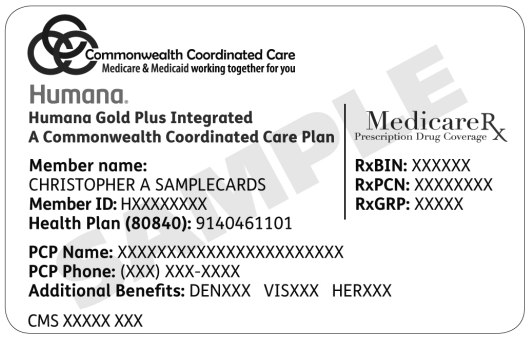
The contract is in effect for the months you are enrolled in Humana Gold Plus Integrated between January 1, 2017 and December 31, 2017.

J. What other information will you get from us?

You should have already gotten a Humana Gold Plus Integrated member ID Card, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your Humana Gold Plus Integrated Member ID Card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:


Commonwealth Coordinated Care
Medicare & Medicaid working together for you
Humana.
Humana Gold Plus Integrated
A Commonwealth Coordinated Care Plan
MedicareRx
Prescription Drug Coverage
Member name:
CHRISTOPHER A SAMPLECARDS
Member ID: HXXXXXXXX
Health Plan (80840): 9140461101
RxBIN: XXXXXX
RxPCN: XXXXXXXX
RxGRP: XXXXX
PCP Name: XXXXXXXXXXXXXXXXXXXXXXX
PCP Phone: (XXX) XXX-XXXX
Additional Benefits: DENXXX VISXXX HERXXX
CMS XXXXX XXX
SAMPLE


Member Service: 1-855-280-4002
Pharmacist/Physician Rx Inquiries: 1-800-865-8715
HumanaFirst Nurse Advice Line: 1-855-235-8579
Website: Humana.com
Send claims to:
Humana Medical Claims
PO Box 14601
Lexington, KY 40512-4601
Beacon Health Strategies
10200 Sunset Drive
Miami, FL 33173
LTSS Claims
ILS
PO Box 21596
Eagan, MN 55121
If you use a TTY, call 711
SAMPLE

If your card is damaged, lost, or stolen, call Customer Care at the number at the bottom of the page right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Humana Gold Plus Integrated network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 27).

➤ You can ask for an annual *Provider and Pharmacy Directory* by calling Customer Care at the number at the bottom of the page. You can also see the *Provider and Pharmacy Directory* on our website at **Humana.com**. You can also download it from this website.

The Provider and Pharmacy Directory lists health care professionals, facilities, and support providers that you may see as a Humana Gold Plus Integrated member. We also list the pharmacies that you may use to get your prescription drugs.

What are "network providers"?

- Network providers include:
  - Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and
  - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.
- Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Customer Care at the number at the bottom of the page for more information. Both Customer Care and Humana Gold Plus Integrated Plan's website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a *List of Covered Drug*s. We call it the "Drug List" for short. It tells which prescription drugs are covered by Humana Gold Plus Integrated.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, Section B, on page 83 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit **Humana.com** or call Customer Care at the number at the bottom of the page. This call is free.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Care at the number at the bottom of the page.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing facility or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Customer Care at the number at the bottom of the page.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8, Section D, page 106.

Chapter 2: Important phone numbers and resources

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A. How to contact Humana Gold Plus Integrated Customer Care

CALL	1-855-280-4002 This call is free. We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours of operation are the same as above
WRITE	Humana PO Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com**

Contact Customer Care about:

- **Questions about the plan**
- **Questions about claims, billing or member ID Cards**
- **Coverage decisions about your health care**

  A coverage decision about your health care is a decision about:

  – your benefits and covered services, ***or***

  – the amount we will pay for your health services.

  Call us if you have questions about a coverage decision about health care.

  ➤ To learn more about coverage decisions, see Chapter 9, Section 4, page 124

- **Appeals about your health care**

  An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

  ➤ To learn more about making an appeal, see Chapter 9, Section 4, page 124

- **Complaints about your health care**

  You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).

  ➤ If your complaint is about a coverage decision about your health care, you can make an appeal. (See the section above.)

  ➤ You can send a complaint about Humana Gold Plus Integrated right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

  ➤ To learn more about making a complaint about your health care, see Chapter 9, Section 10, page 157

- **Coverage decisions about your drugs**

  A coverage decision about your drugs is a decision about:

  – your benefits and covered drugs, ***or***

  – the amount we will pay for your drugs.

  This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.

  ➤ For more on coverage decisions about your prescription drugs, see Chapter 9, Section 6.4, page 140

- **Appeals about your drugs**

  An *appeal* is a way to ask us to change a coverage decision. You can file an appeal by calling Customer Care at the number at the bottom of the page or by writing to us using the address below:

  Humana Inc.
  Grievance and Appeal Department
  PO Box 14546
  Lexington, KY 40512-4546
  Expedited Fax: 1-855-336-6220

  ➤ For more on making an appeal about your prescription drugs, see Chapter 9, Section 6.5, page 142

- **Complaints about your drugs**

  You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

  If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. *(See the section above.)*

  You can send a complaint about Humana Gold Plus Integrated right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

  ➤ For more on making a complaint about your prescription drugs, see Chapter 9, Section 10, page 157

- **Payment for health care or drugs you already paid for**

  ➤ For more on how to ask us to pay you back, or to pay a bill you have gotten, see Chapter 7, Section A, page 100

  ➤ If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Section 4, page 124 for more on appeals.

B. How to contact your Care Manager

With your Humana Gold Plus Integrated Plan, you have a whole care team to work with to help support meeting your health needs and goals. This service is part of this plan and there is no cost to you.

You are key to your care team and will be able to visit with your own personal care manager by telephone. In-person home visits may also be available if you have complex health, mental health or long-term service needs.

Your care manager will work with you and any family members or other caregivers you choose. Your care manager can help you stay healthy by making sure that you and your providers work together to meet all of your health care needs. We are here to help you understand and follow their treatment plan and instructions. Working with you, your care manager may also involve other health professionals like nurses, social workers, long-term service and mental health specialists – this is your care team.

Our care managers are here to work with you. For example, your care manager may:

- Support you in finding ways to manage your health
- Answer your health questions
- Work with you and your doctors to develop a care plan that meets your needs
- Help you make sure you have all your medicines and know how to take them
- Support you if you have chronic conditions such as diabetes, heart disease and other illnesses

- Support your health goals and help you reach them
- Help connect you with community services where you live
- Arrange for support after a hospitalization
- Help you return to the community after a nursing home or inpatient stay
- Develop a crisis plan to help in times of emergency
- Making it easier for you to stay in your home

To contact your care manager or if you want to change your care manager or have questions about our chronic condition programs and how to start or stop getting the program services:

CALL	1-855-280-4002 This call is free. We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours of operation are the same as above.
WRITE	Humana PO Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com**

Contact your care manager about:

- **Questions about your health care**
- **Assistance with appointment scheduling**
- **Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)**

  Long-term services and supports (LTSS) are a variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and

transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities.

Sometimes you can get help with your daily health care and living needs. You may be able to get these services if you are eligible for the Elderly & Disabled with Consumer Direction (EDCD) waiver:

- Adult Day Health Care
- Personal Care, including consumer-directed or agency model
- Personal Emergency Response System, including medication monitoring
- Respite Care, including consumer-directed or agency model
- Transition Coordination
- Transition Services

C. How to contact the Nurse Advice Call Line

The Nurse Advice Call Line is a free service for plan members for assistance with questions you may have about your healthcare.

CALL	1-855-235-8579 This call is free. We're available 24 hours per day, 7 days per week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. We're available 24 hours per day, 7 days per week.

Contact the Nurse Advice Call Line about:

- Questions about your health care

If you have an emergency, call 911.

The Nurse Advice Call Line is a free service for plan members. You can call anytime to speak with one of our nurses if you are sick or hurt, need healthcare advice or are not sure where to go.

A Nurse will ask questions about your problem and help you decide if you need to go to the hospital, call the doctor or care for yourself at home.

D. How to contact the Behavioral Health Crisis Line

CALL	1-855-235-8579 This call is free. We're available 24 hours per day, 7 days per week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. We're available 24 hours per day, 7 days per week.

Contact the Behavioral Health Crisis Line about:

- **Questions about behavioral health services**

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP).

VICAP is not connected with any insurance company or health plan.

CALL	1-800-552-3402 This call is free.
TTY	TTY users dial 711
WRITE	Virginia Insurance Counseling and Assistance Program 1610 Forest Avenue, Suite 100 Henrico, Virginia 23229
EMAIL	aging@dars.virginia.gov
WEBSITE	http://www.vda.virginia.gov/vicap2.asp

Contact Virginia Insurance Counseling Assistance Program (VICAP) about:

- **Questions about your Medicare health insurance**

  VICAP counselors can:

  - help you understand your rights,
  - help you understand your plan choices, and
  - answer your questions about changing to a new plan.

F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called KEPRO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

CALL	1-844-455-8708
TTY	1-855-843-4776
WRITE	5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	http://www.keproqio.com/

Contact KEPRO about:

- **Questions about your health care**

  You can make a complaint about the care you got if:

  - You have a problem with the quality of care,
  - You think your hospital stay is ending too soon, ***or***
  - You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Forms, Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about your Medicaid eligibility, contact the Department of Social Services in the city or county where you live. If you have questions about the services you get under Medicaid, call the Department of Medical Assistance Services (DMAS). Contact information for DMAS is in the table below.

CALL	804-786-6145
TTY	1-800-343-0634
WRITE	Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, Virginia 23219
EMAIL	dmasinfo@dmas.virginia.gov
WEBSITE	http://www.dmas.virginia.gov

I. How to contact the Office of the State Long-Term Care Ombudsman (Commonwealth Coordinated Care Advocate)

The Commonwealth Coordinated Care Ombudsman can help you if you are having a problem with Humana Gold Plus Integrated. The Ombudsman is not connected with us or with any insurance company or health plan. The services are free.

CALL	1-800-552-5019 This call is free.
TTY	1-800-464-9950 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Commonwealth Coordinated Care Ombudsman Virginia Department for Aging and Rehabilitative Services 8004 Franklin Farms Drive Henrico, Virginia 23229
FAX	804-662-9140
WEBSITE	http://www.ElderRightsVA.org

J. Other resources

Area Agencies on Aging or AAAs

AAA offers many services for older adults. They may also help you learn about other services. Each AAA has a local board who knows about the needs of their area.

CALL	1-804-644-2804
WRITE	Virginia Association of Area Agencies on Aging 24 E. Cary Street, Suite 100 Richmond, Virginia 23219
EMAIL	info@thev4a.org
WEBSITE	http://vaaaa.org/

How to join the Virginia Community Connection Committee

Humana Gold Plus Integrated, is excited to present you with the chance to improve your health plan. We invite you to join your Community Connection Committee. On the committee, you share with us how we can better serve you. Attending allows you and your caregiver, or family member, the chance to meet other plan members in your community. The two hour meetings will take place once every three months. If you can't attend in person, you can join us by phone. Lunch is included at every meeting. Humana wants to hear how we can improve your health plan. If you would like to attend or would like more information, please contact the Virginia Quality Department through the methods below. The Virginia Quality Department is open Monday - Friday between the hours of 8 a.m. and 5 p.m. Eastern time.

CALL	1-855-237-6797 Monday through Friday between the hours of 8 a.m. - 5 p.m. Eastern time
TTY	711
FAX	1-855-700-5103
WRITE	Community Connection Committee Attn: Virginia Quality Department 4191 Innslake Drive Suite 100 Glen Allen, VA 23060-3324
EMAIL	VAQualityCCC@**Humana.com**
WEBSITE	www.**Humana.com**/medicare/medicaid-dual/

Chapter 3: Using the plan's coverage for your health care and other covered services

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A. About "services," "covered services," "providers," and "network providers""

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, Section D, page 42.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

Humana Gold Plus Integrated covers all services covered by Medicare and Medicaid. This includes behavioral health, long-term care and prescription drugs.

Humana Gold Plus Integrated will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D, page 42 of this handbook).
- The care must be **medically necessary**. *Medically necessary* means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status, or an item or service provided for the diagnosis or treatment of your condition consistent with standards of medical practice. This includes care that keeps you from going into a hospital or nursing home.
- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to see another doctor. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, your network PCP must give you approval before you can use other providers in the plan's network. This is called a **referral**. To learn more about referrals, see Chapter 3, Section D, page 28.
  - You do not need a referral from your PCP for emergency care or urgently needed care or to see a women's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see Chapter 3, Section D, page 28.
    - ➤ To learn more about choosing a PCP, see Chapter 3, Section D, page 28.

- **Please note:** In your first 180 days with our plan, you may continue to see your current providers, at no cost, including providers that are not a part of our network. During the 180 days, our care manager will contact you to help you find providers in our network. After 180 days, we will no longer cover your care if you continue to see out-of-network providers.

  In addition, we will allow you to maintain your prior authorized services for the duration of the prior authorization or for 180 days after you first enroll, whichever is sooner. If you are in a nursing facility at the start of the CCC Program, you may remain in the facility as long as you continue to meet the criteria for nursing facility care, unless you or your family prefers to move to a different nursing facility or return to the community. Nursing home criteria are established by the Virginia Department of Medical Assistance Services.

- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 33.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. Your PCP will arrange for this out-of-network care. You must obtain authorization from the plan prior to seeking care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see page 32.
  - The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue seeing any out-of-network providers you see now for 180 days.
  - If you leave our plan and enroll in another Medicare-Medicaid Plan, you can continue seeing any out-of-network providers you see now for 30 days.

C. Your care manager

With your Humana Gold Plus Integrated Plan, you have a whole care team to work with to help support meeting your health needs and goals. This service is part of this plan and there is no cost to you.

You are key to your care team and will be able to visit with your own personal care manager by telephone. Your care manager will perform a health risk assessment when you join the plan as discussed in Chapter 1. Reassessments will also occur annually, if requested, or if your condition changes. In-person home visits may also be available if you have complex health, mental health or long-term services and supports needs.

Your care manager will work with you and any family members or other caregivers you choose.

Your care manager can help you stay healthy by making sure that you and your providers work together to meet all of your health care needs. We are here to help you understand and follow your treatment plan and instructions. Working with you, your care manager may also involve other health professionals like nurses, social workers, long-term service and mental health specialists – this is your care team.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

Our care managers are here to work with you. For example, your care manager may:

- Support you in finding ways to manage your health
- Answer your health questions
- Support you if you have chronic conditions such as diabetes, heart disease and other illnesses
- Work with you and your doctors to develop a care plan that meets your needs
- Help you make sure you have all your medicines and know how to take them
- Support your health goals and help you reach them
- Help connect you with community services where you live
- Arrange for support after a hospitalization
- Help you return to the community after a nursing home or inpatient stay
- Develop a crisis plan to help in times of emergency
- Make it easier for you to stay in your home

To contact your care manager or if you want to change your care manager or have questions about our chronic condition programs and how to start or stop getting the program services, call Customer Care at the number at the bottom of the page.

D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

Your Primary Care Provider (PCP)

Your PCP will work with you to coordinate all your health care. Your PCP will do your checkups and treat most of your routine health care needs. If needed, your PCP may send you to specialists. You can reach your PCP by calling his/her office. Your PCP's name and phone number are printed on your Member ID Card. It is important to call your PCP when you need medical care. You may also be seen by your PCP's assistant or a nurse.

Your Medical Home

Your PCP will become your medical home. As a medical home, the PCP is your primary source for healthcare. They will refer you to a specialist if needed. They will also help manage your chronic conditions. You should have an ongoing, trusting relationship with your PCP. Your PCP knows your medical history. A medical home also includes the support team who works with your PCP to coordinate the services and care you need. The goal is to help you be as healthy as possible.

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

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

Your PCP may be one of the following types of health care providers:

- Family practice
- General practitioner
- Internal medicine
- Geriatric practitioner
- Nurse practitioner and Physician Assistants
- Federally Qualified Health Center, Rural Health Clinic, and Health Departments
- Women's health specialists or OB/GYN

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

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 Humana Gold Plus Integrated. There is a process the specialists must go through to be your PCP.

How do you choose your PCP?

For information on choosing your PCP, call Customer Care at the number at the bottom of the page.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP.

If you want to change your PCP for any reason, you must call Customer Care at the number at the bottom of the page to let us know. Change requests we get by the last day of the month will usually be effective on the first day of the following month. We will send you a new member ID Card with your new PCP on it. Customer Care can also help you schedule your first appointment, if needed.

To find the PCPs you can choose from:

- Look in our Provider and Pharmacy Directory
- Look on our website at **Humana.com**.
- Call Customer Care at the number at the bottom of the page

If you need a copy of the Provider and Pharmacy Directory, call Customer Care at the number at the bottom of the page.

Services you can get without first getting approval from your PCP

- In most cases, you will need approval from your PCP before seeing other providers. This approval is called a **referral**. You can get services like the ones listed below without first getting approval from your PCP:
- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Customer Care before you leave the service area. We can help you get dialysis while you are away).
- Flu shots, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.
- All covered preventive services as long as you get them from a network provider.
- Outpatient mental health and substance abuse medication management, assessments, consultation and therapy with in network providers.
- Emergency or crisis treatment for mental health and substance abuse problems.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

Your PCP can recommend a specialist to you if you have a specific problem. Your PCP can also recommend a lab or hospital to you for special services.

You may need a referral to see a specialist or someone that is not your PCP. A referral means that your network PCP must give you approval before you can see the other provider. If you don't get a referral, Humana Gold Plus Integrated may not cover the service. If you are seeing a specialist for your care, you may need to return to your PCP for a referral for additional services.

We may need to review and approve service requests before you can get services from a specialist. The specialist, lab or hospital will know how to get approval for these services. This is called getting "prior authorization". See Chapter 4, Section C, page 41 for information about which services require prior authorization.

If there are specific specialists you want to use, find out whether your PCP sends patients to see these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a plan specialist that your current PCP can't refer you to. Earlier in this section, under "Changing your PCP," we explained how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP, or the doctors you will be seeing, use these hospitals.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. If you have questions, you can call us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

How to get care from out-of-network providers

Your network PCP or plan must give you approval in advance before you can use providers not in the plan's network. This is called giving you a "referral." For more information about this and situations when you can see an out-of-network provider without a referral (such as an emergency), see page 33 of this chapter. If you don't have a referral (approval in advance) before you get services from an out-of-network provider, you may have to pay for these services yourself.

For some types of services, your doctor may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4, Section C, page 41 for more information about which services require prior authorization.

- **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

E. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) are a variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities, but also in facility-based settings such as nursing facilities.

You would need to contact your local DSS/health department for a LTSS screening. If you need assistance with contacting your local agency, call Customer Care at the number at the bottom of the page and ask to speak to your care manager. You may choose which provider/agency you want to provide your long-term services and supports. A list of agencies approved to provide services in your service area will be reviewed with you by your Humana Gold Plus Integrated care manager.

F. How to get consumer-directed care

Consumer-directed care allows you the member to hire, train, and supervise your own caregiver for personal care services. Depending on your LTSS Waiver eligibility and approval from Department of Medical Assistance Services (DMAS), you may direct your personal care and/or respite services. This service includes activities such as:

- Bathing

- Dressing
- Meal Preparation
- Respite

If you qualify, your care manager can assist you with signing up for consumer-directed care.

G. How to get behavioral health services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance abuse disorder, such as Depression, Anxiety, or Drug Addiction. These services aim to help individuals live in the community and help them to maintain the most independent and satisfying lifestyle possible. Services range from counseling to hospital care, including day treatment and crisis services. Services can be provided in homes and in the community, on a short- or long-term basis, and all are performed by qualified individuals and organizations.

You are encouraged to speak with a healthcare professional about your concerns and seek an evaluation if you are having trouble coping with feelings and thoughts.

For behavioral health services, please call Customer Care at the number at the bottom of the page.

Our Customer Care staff can answer questions about behavioral health services and help you find a provider who can help you feel better.

H. How to get transportation services

- For emergency transportation services, call 911.
- If you need a ride to a health care appointment that is not an emergency, call 1-855-253-6869, Monday - Friday 8 a.m. - 5 p.m. Eastern time. Call TTY 1-866-288-3133. Please call at least 3 days in advance when possible. See Chapter 4, Section D, page 73 for more information about transportation.
- If your transportation is late in arriving, call the Transportation Help Line at 1-855-253-6870. Call TTY 1-866-288-3133.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson (meaning a person with an average knowledge of health and medicine) could expect it to result in:

- serious risk to your health; ***or***

- serious harm to bodily functions; ***or***
- serious dysfunction of any bodily organ or part; ***or***
- in the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery.
  - The transfer may pose a threat to your health or safety or to that of your unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Call Humana Gold Plus Integrated at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, Section D, page 43.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider, ***or***
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider, ***and***
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

If you think you need urgent care, you can:

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

OR

2. Call our 24-hour nurse advice line at 1-855-235-8579 (TTY: 711).

OR

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

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➤ Our plan does not cover urgently needed care or any other non-emergency care that you get outside the United States.

Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Humana Gold Plus Integrated.

Please visit our website for information on how to obtain needed care during a declared disaster: **Humana.com**.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at the in-network cost-sharing rate. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

J. What if you are billed directly for the full cost of services covered by our plan?

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay our share of the bill.

➤ **You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

If you have paid more than your share for covered services, or if you have gotten a bill for the full cost of covered medical services, see Chapter 7, Section A, page 100 to learn what to do.

What should you do if services are not covered by our plan?

Humana Gold Plus Integrated covers all services:

- that are medically necessary, ***and***
- that are listed in the plan's Benefits Chart (see Chapter 4, Section D, page 42), ***and***
- that you get by following plan rules.

➤ If you get services that aren't covered by our plan, **you must pay the full cost yourself**.

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section 5, page 126 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Customer Care to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Customer Care to find out what the limits are and how close you are to reaching them.

K. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study.

Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your care manager should contact Customer Care.

When you are in a clinical research study, who pays for what?

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study.**

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.
  - You are covered for an unlimited number of medically necessary inpatient hospital days. See Chapter 4, Section D, page 42 (Medical Benefits Chart) for more information.

M. Rules for owning durable medical equipment

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

Will you own your durable medical equipment?

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of Humana Gold Plus Integrated, however, you usually will not own the rented equipment, no matter how long you rent it.

Even if you had the durable medical equipment for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

What happens if you switch to Original Medicare?

You will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

➤ There are no exceptions to this case when you return to Original Medicare.

Chapter 4: Benefits Chart

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A. Understanding your covered services

This chapter tells you what services Humana Gold Plus Integrated pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section B, page 83. This chapter also explains limits on some services.

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3, Section B, page 26 for details about the plan's rules.

If you need help understanding what services are covered, call your care manager *or* Customer Care at the number at the bottom of the page.

B. Our plan does not allow providers to charge you for services

We do not allow Humana Gold Plus Integrated providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

➤ **You should never get a bill from a provider for covered services. If you do, see Chapter 7, Section A, page 100 or call Customer Care at the number at the bottom of the page.**

C. About the Benefits Chart

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 28 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can see other network providers. This is called a referral. Chapter 3, Section D, page 28 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization*. Covered services that need approval first are marked in the Benefits Chart by an asterisk (*). In addition, you must get approval first for the following services that are not listed in the Benefits Chart:

- Automatic Implantable Cardioverter Defibrillators (AICD)
- Pain Management Procedures
- Hyperbaric Therapy
- Infertility Testing and Treatment
- Varicose Vein: Surgical Treatment and Sclerotherapy
- Ventricular Assist Devices
- Cardiac Implants
- Sleep Studies
- Transthoracic Echocardiogram (TTE)
- Coronary Angioplasty/Stent Procedures
- Bone Growth Stimulators
- Spinal Fusion
- 3D Mammography
- Transcranial Ultrasound
- Carotid Endarterectomy (CEA) and Carotid Artery Stenting (CAS) and Carotid/Aorta Doppler
- Pulmonary Stress Testing
- Doppler Ultrasound of Extremity
- Pulse Volume Recording
- Cardiac Ablation
- Cardioversion
- Transaortic Valve Replacement (TAVR)
- Dental Anesthesia
- Genetic/molecular testing
- Hearing (auditory) devices or implants

All preventive services are free.

D. The Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening The plan will pay only once for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0 copay
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0 copay

Services that our plan pays for	What you must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are *not* emergencies, the plan *may* pay for an ambulance. See the transportation section for information on non-emergency transportation.	$0 copay
Bone mass measurement The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0 copay
Breast cancer screening (mammograms) The plan will pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	$0 copay
Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well.	$0 copay
Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0 copay
Cervical and vaginal cancer screening The plan will pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical cancer: one Pap test every 12 months • For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	$0 copay
Chiropractic services The plan will pay for the following services: • Adjustments of the spine to correct alignment	$0 copay *Prior authorization and/or referral may be required
Clinic services The plan will pay for clinic services that are preventive, diagnostic, therapeutic, rehabilitative, or palliative.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Colorectal cancer screening • For people 50 and older, the plan will pay for the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	$0 copay

Services that our plan pays for	What you must pay
Community mental health rehabilitation services The plan will pay for medically necessary community mental health rehabilitation services. Authorization may be required. Services include: • **Psychosocial rehabilitation** – Services provided to groups of adults in a non-residential setting. Services are generally provided using a clubhouse model that gives you a supportive environment where you can: – get an assessment of your mental illness, – learn about your mental illness and medicines that can help, – learn and use independent living skills, and – enhance your social and interpersonal skills. • **Day treatment/partial hospitalization** – Short term services to stabilize your psychiatric condition. Services are time-limited interventions that are more intensive than outpatient services. • **Mental health skill-building services** – Services to help you learn functional skills and appropriate behavior that you may need as related to your significant mental illness so you can live independently in your community. Services are provided in the most appropriate and least restrictive environment. • **Intensive community treatment** – A variety of services that help you function in your community if you have serious emotional illness and need intensive levels of support. • **Crisis intervention** – Immediate mental health care to assist you if you are having a psychiatric emergency. Services are available 24 hours a day, seven days a week. • **Crisis stabilization** – Direct mental health services that are available if you are not in the hospital and are having a psychiatric emergency that could lead to you being unable to live in your current community.	$0 copay *Prior authorization and/or referral may be required
Compliance Packaging Helps members take the right drugs at the right time by packing their drugs based on dosage and the time when they are to be taken. *Limited to Elderly or Disabled with Consumer Direction (EDCD) waiver members with severe mental impairment.	$0 copay

Services that our plan pays for	What you must pay
Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. If you are pregnant, you can get additional support to help you stop smoking. See the Pregnancy Services section for more information. You are covered for an additional smoking cessation benefit: • The plan will pay for 1 additional counseling quit attempt in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. • You are also eligible to receive Nicotine Replacement Therapy products (gum, lozenges, and patches) through your OTC benefit.	$0 copay
Court ordered services The plan will pay for all medically necessary court ordered services.	$0 copay
Dental services Humana Gold Plus Integrated will pay for dental services that are provided by a medical doctor when you've been in an accident. You are also covered for the following additional routine dental benefits: – 1 comprehensive oral evaluation per year – 1 prophylaxis (cleaning) per year – 1 filling (amalgam or composite) per year – 1 set bite wing x-rays per year – 1 panoramic x-ray per 3 years	$0 copay
Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0 copay

Services that our plan pays for	What you must pay
Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months	$0 copay
Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • The plan will pay for training to help you manage your diabetes, in some cases.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies Durable medical equipment (DME) and related supplies are medically necessary supplies and equipment ordered by your doctor for use at home. The following items are covered: • Crutches • Hospital beds • IV infusion pumps • Nebulizers • Oxygen and Respiratory equipment and supplies • Positioning devices • Prone standers • Walkers • Wheelchairs • Speech generating devices Other items *may* be covered. We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Elderly or Disabled with Consumer Direction (EDCD) waiver services This is a home and community-based waiver whose purpose is to provide care in the community rather than in a nursing facility. EDCD waiver services provided by the plan include: • **Adult day health care** – Health maintenance and rehabilitation coordination services that you get in a group setting during the day. These services are meant to help you stay well enough so that you do not need to go to a nursing facility. • **Agency and/or consumer-directed personal care services** – Long-term maintenance or support services that you need in order to live at home instead of in a nursing facility. • **Agency and/or consumer-directed respite care services** – Short-term personal care services provided to you when your unpaid caregiver who normally provides your care is absent or needs a break. • **Consumer-directed service facilitation** – Help with hiring, training, and supervising personal care aides, who perform basic health-related services. • **Personal emergency response systems** – An electronic device and monitoring service that you use to get help in an emergency. This benefit is available to certain people who are at high risk of going to a nursing facility or other institution. • **Medication monitoring services** – An electronic device that reminds you to take your medications at the correct dosages and times. This benefit is for people who are at high risk of going to a nursing facility or other institution. • **Transition coordination** – Help planning your move from a nursing facility to your home. • **Transition services** – Help with expenses when you are moving from a nursing facility or other institution to a private residence where you are responsible for your own living expenses. Nursing facility or other institution includes a licensed or certified provider-operated living arrangement. To get EDCD services, the State has to make sure you meet certain criteria. If you need EDCD waiver services, you can contact Humana Gold Plus Integrated at 1-855-280-4002 (TTY: 711) to ask about the process for applying for these services. We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. You can also call the State's Long-Term Care Division at 804-225-4222 for additional information.	$0 copay *Prior authorization and/or referral may be required For Long-Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long-term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or get EDCD Waiver services. However, you might not end up having to pay each month.

Services that our plan pays for	What you must pay
Emergency care *Emergency care* means services that are: • given by a provider trained to give emergency services, ***and*** • needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health; ***or*** • serious harm to bodily functions; ***or*** • serious dysfunction of any bodily organ or part; ***or*** • in the case of a pregnant woman, in active labor, meaning labor at a time when either of the following would occur: – There is not enough time to safely transfer you to another hospital before delivery. – The transfer may pose a threat to your health or safety or to that of your unborn child. Your coverage for emergency care is within the U.S. and its territories.	$0 copay If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.
Enhanced disease management Additional enhanced care management outreach involves telephonic contact and in home assessments and referrals to add-on services. For conditions such as: • Weight Management • Chronic Condition Management • Back Health and Care	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will pay for the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling The plan will also pay for some other family planning services. However, you must see a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing	$0 copay *Prior authorization and/or referral may be required for the following services: • Genetic counseling • Treatment for medical conditions of infertility • Treatment for AIDS and other HIV-related conditions • Genetic testing
Health and wellness education programs • Online and printed health education materials and tools • Nutrition counseling • Disease management programs	$0 copay

Services that our plan pays for	What you must pay
Health and wellness education programs **Fitness** Silver Sneakers is a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness and may include classes specifically for older adults. These classes are focused on physical activity. Partner clubs provide access to an orientation to the facility and equipment along with access to club amenities. In addition, this program includes a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. The at-home package includes information and tools for the member to exercise in their own home.	$0 copay
Health and wellness education programs **Post-Discharge Meal Program** After your inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 5 days, at no cost to you. Ten nutritious, pre-cooked frozen meals will be delivered to your home. Meal program limited to 4 times per calendar year. Please contact Well Dine at 1-866-96MEALS (1-866-966-3257) for further details or to take advantage of this benefit after your discharge.	$0 copay
Health and wellness education programs **Pregnancy Education** Patient education services to pregnant women, including twelve classes in a planned, organized teaching environment. Six allowed for childbirth education and six allowed for parenting education.	$0 copay
Health and wellness education programs **Pregnancy Nutritional Education** Three classes of nutritional education services to every pregnancy. This includes one nutritional assessment of dietary habits and two follow-ups.	$0 copay

Services that our plan pays for	What you must pay
Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan also covers the following: • Basic and advanced hearing tests • Hearing aid counseling • Evaluation for hearing aid • Unlimited fittings for hearing aid • Hearing aids one per ear every three years • $1,000 Maximum Benefit amount for hearing aids every 3 years • 16 hearing aid batteries every year	$0 copay *Prior authorization and/or referral may be required
HIV screening The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, ***or*** • are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0 copay

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them. These services must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copay *Prior authorization and/or referral may be required
Home health aide services The plan covers services from a licensed nurse or a home health aide for members who qualify. Home health aide services are limited to 32 visits per year. Services may include the following: • Rehabilitation therapies, including physical therapy, occupational therapy, and speech-language therapy • B-12 shots • Insulin injections • Central line and portacath flushes • Blood draws for people who are medically unstable or morbidly obese • Indwelling catheter changes	$0 copay *Prior authorization and/or referral may be required
Immunizations The plan will pay for the following services: • 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 • Other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section G, page 97 to learn more.	$0 copay

Services that our plan pays for	What you must pay
Inpatient hospital care The plan will pay for the following services, 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 use disorder treatment services, including medically managed detoxification in an acute setting (see Substance use disorder treatment for more information about these services) • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See the Transplants section for more information. • Blood, including storage and administration – The plan will pay for whole blood, packed red cells, and all other parts of blood beginning with the first pint used. • Physician services	$0 copay You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. *Prior authorization and/or referral may be required
Inpatient mental health care • The plan will pay for mental health care services that require a hospital stay. • The plan will pay for mental health care services required by a Temporary Detention Order (TDO). A court can order a TDO when a person presents with a substantial risk of harm to self or others. The local Community Services Board then does a psychiatric evaluation to determine whether an involuntarily hospitalization is necessary.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not medically necessary, the plan will not pay for it. However, in some cases the plan will pay for services you get while you are in the hospital or a nursing facility. The plan will pay for the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: – replace all or part of an internal body organ (including contiguous tissue), or – replace all or part of the function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition • Physical therapy, speech therapy, and occupational therapy	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Kidney disease services and supplies The plan will pay for the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 26. • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" in this chart.**	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Long-Term Services and Supports (LTSS) The plan will cover long-term services and supports (LTSS). LTSS help elderly people or people with disabilities with their daily needs. Before you can get LTSS, Humana Gold Plus Integrated will make sure you qualify for the services. LTSS include help with: • Bathing • Dressing • Using the toilet • Transferring (for example, moving between the bed, chair, and/or wheelchair) • Laundry • Meal preparation • Housekeeping • Transportation LTSS also include: • Nursing Facility Care (see the Nursing facility care section for more information) • Elderly or Disabled with Consumer Direction (EDCD) waiver services (see the EDCD waiver services section for more information)	For Long-Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long-term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or receive EDCD Waiver services. However, you might not end up having to pay each month. *Prior authorization and/or referral may be required *Waiver may be required

Services that our plan pays for	What you must pay
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 55-77, *and* • Have a counseling and shared decision-making visit with your doctor or other qualified provider, *and* • Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0 copay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.	$0 copay

Services that our plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Humana Gold Plus Integrated will pay for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, or Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases ➤ **Chapter 5, Section Introduction, page 80 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➤ **Chapter 6, Section Introduction, page 92 explains what you pay for your outpatient prescription drugs through our plan.**	$0 copay *Prior authorization and/or referral may be required
Non-Medicaid Over-the-Counter Drugs You are eligible for up to $25 monthly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness products available through Humana Pharmacy®, our mail order pharmacy. The order form can be obtained by calling Customer Care at the number at the bottom of the page.	$0 copay

Services that our plan pays for	What you must pay
Nurse Advice Call Line (HumanaFirst®) If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, Humana can help. Call HumanaFirst, our advice line for members, 24 hours a day, seven days a week at 1-855-235-8579 (TTY 711). It's staffed by nurses who can help address your immediate health concerns and answer questions about particular medical conditions.	$0 copay
Nursing facility care and skilled nursing facility care The plan will pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration – The plan will pay for whole blood, packed red cells, and all other parts of blood beginning with the first pint used • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse lives at the time you leave the hospital. • The nursing home where you were living when you enrolled in Humana Gold Plus Integrated.	For Long-Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long-term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or receive EDCD Waiver services. However, you might not end up having to pay each month. Patient pay responsibility does not apply to Medicare-covered days in a nursing facility. Must meet state, DMAS, and or long-term care criteria. *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Nurse midwives The plan will cover services provided by nurse midwives as allowed under State licensure requirements and Federal law.	$0 copay *Prior authorization and/or referral may be required
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0 copay
Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration • Other outpatient diagnostic tests	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Outpatient hospital services The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some screenings and preventive services • Some drugs that you can't give yourself	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Outpatient mental health care The plan will pay for mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, ***or*** • any other Medicare-qualified mental health care professional as allowed under applicable state laws. The plan will pay for the following medically necessary services, and maybe other services not listed here. Services may require authorization. The plan covers the following services: • Psychiatric diagnostic exams • Individual medical psychotherapy • Group medical psychotherapy • Family medical psychotherapy • Electroconvulsive therapy • Psychological / Neuropsychological testing • Medication management (these visits are not counted as part of your maximum yearly visits) • Outpatient substance use treatment and support services (see Substance use disorder treatment for more information about these services)	$0 copay *Prior authorization and/or referral may be required
Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 copay *Prior authorization and/or referral may be required
Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Partial hospitalization services *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. See Substance use disorder treatment for more information about substance use partial hospitalization programs. hospitalization programs.	$0 copay *Prior authorization and/or referral may be required
Pest control The plan covers pest control service 4 times per year with a $65 maximum per service. The benefit can only be utilized once every 3 months.	$0 copay Pest control service excludes Cimex Lectularius Linnaeus (Insecta: Hemiptera: Cimicidae), commonly known as bed bugs *Prior authorization and/or referral may be required EDCD Waiver Eligibility Required

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits The plan will pay for the following services: • Medically necessary health care or surgery services given in places such as: – physician's office – certified ambulatory surgical center – hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider, if your doctor orders it to see whether you need treatment • Some telehealth services (also called telemedicine), which is when your provider uses interactive/video connections to share information with other providers to help diagnose, treat, or monitor your condition. Providers can use telehealth only in approved areas and only if you agree. • Second opinion from a qualified health care professional within the provider network, or we will arrange for you to obtain one outside the provider network, at no cost to you. • Non-routine dental care. Covered services are limited to: – surgery of the jaw or related structures, – setting fractures of the jaw or facial bones, – pulling teeth before radiation treatments of neoplastic cancer, ***or*** – services that would be covered when provided by a physician.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Podiatry services The plan will pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes You are also covered for additional podiatry services. You may self-refer for 6 visits per year to a network specialist for the services below: • Treatment of flat feet or other structural misalignments of the feet • Removal of corns • Removal of warts • Removal of calluses • Hygienic care	$0 copay *Prior authorization and/or referral may be required
Pregnancy services The plan will pay for the following pregnancy-related services: pregnancy education classes, nutritional assessment and counseling, homemaker services, blood glucose meters when medically necessary, and follow-up visits if you leave the hospital less than 48 hours after having your baby. The plan also pays for coordination and case management services if you have a high-risk pregnancy. Covered services include: • An assessment to determine your psychosocial, nutritional, and medical needs • A plan to help you get what you need for your pregnancy • Help with connecting you to providers and making sure all your providers are working together • Counseling to stop smoking or tobacco use	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0 copay
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Eye prostheses The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See "Vision Care" later in this section on page 74 for details. The plan will not pay for prosthetic dental devices.	$0 copay *Prior authorization and/or referral may be required
Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
Respite care In home respite services that allow members to stay in their home and receive care that would typically be provided by family or other unpaid caregivers.	For Long-Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long-term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or receive EDCD Waiver services. However, you might not end up having to pay each month. Up to 480 hours per calendar year. *Prior authorization and/or referral may be required EDCD Waiver Eligibility Required
Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0 copay

Services that our plan pays for	What you must pay
Substance use disorder treatment Effective April 1, 2017 (unless otherwise noted), the plan will pay for the following substance use disorder treatment services when medically necessary. Services may require authorization). • **Substance use case management.** The plan pays for the following services for members and their families: – assistance with accessing needed medical, psychiatric and substance use disorder treatment services – assistance with linking to social, educational, vocational and other supports essential to meeting basic needs • **Screening, Brief Intervention and Referral to Treatment (SBIRT).** The plan pays for services to help identify members who may have alcohol and/or other substance use problems. Following a screening, the plan provides a brief intervention to educate members about their use, alert them to possible consequences and, if needed, help connect them to treatment services. • **Outpatient substance use treatment services.** The plan pays for: – assistance with accessing needed medical, psychiatric, and substance use disorder treatment services – assessment, evaluation, and medication management – individual, family, and group counseling provided in-person, by telephone, or by telehealth • **Peer recovery services (effective July 1, 2017).** The plan pays for the services of Peer Recovery Specialists, who are individuals in recovery from substance use or co-occurring mental health disorders. Peer Recovery Specialists work with members and family support partners who are impacted by substance use or mental health disorders and provide recovery support in such a way that others can benefit from their experiences. • **Crisis intervention.** The plan pays for immediate care for members who are experiencing acute dysfunction that needs immediate clinical attention. This service is meant to prevent your condition from getting worse, prevent injury to yourself or others, and provide treatment in the least restrictive setting. Services are available 24 hours a day, seven days a week. • **Substance use intensive outpatient programs.** The plan pays for structured services provided to meet the complex needs of members experiencing addiction and co-occurring mental health conditions. Services are provided before and after work or school, in the evening, and on weekends. Services are provided for a minimum of nine (9) hours, with a maximum of nineteen (19) hours per week.	$0 copay *Prior authorization and/or referral may be required

Services that our plan pays for	What you must pay
• **Substance use partial hospitalization programs.** The plan pays for a higher level of structured services for members with a substance use disorder. These services include 20 hours or more of clinically intensive treatment per week, which may include several day-time treatments per week in a non-residential setting. • **Substance use residential treatment.** The plan pays for treatment for substance use disorders for members not in need of hospitalization but who need more structure than can be provided with outpatient services. Residential services are designed to be short term in stay and include a combination of therapeutic services, such as psycho-education, therapeutic supervision, and psychiatric treatment. • **Substance use inpatient treatment.** The plan pays for services provided to members experiencing a medical emergency due to substance use in in an acute care setting or inpatient psychiatric unit. Once medically stable, individuals will transition to a lower level of care. • **Opioid treatment.** The plan pays for services provided by a physician and licensed counselor to treat members with a severe addiction to opioids like fentanyl, heroin, and prescription opioids. Treatment combines psychological and psycho-educational treatment with the administering or dispensing of opioid agonist treatment medication.	
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECOs) A temporary detention order, also called a TDO, is a court order that requires a person to be held in a psychiatric facility for psychiatric evaluation. An emergency custody order, also called an ECO, is issued if an individual needs to be held involuntarily while awaiting a TDO evaluation or while waiting for a hospital bed after the TDO evaluation. The plan will cover services as a result of a TDO or an ECO to assess the need for psychiatric hospitalization and treatment. If a judge determines that you can be transferred without medically harmful consequences, the plan may transfer you to another facility for care and treatment.	$0 copay

Services that our plan pays for	What you must pay
Transplants In some cases, the plan will pay for the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If Humana Gold Plus Integrated provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.	$0 copay *Prior authorization and/or referral may be required
Transportation The plan pays for any medically necessary travel. Non-emergency travel is considered medically necessary when you need help getting to your appointments. The plan covers the following kinds of transportation: • All emergency transportation • Non-emergency air travel • Non-emergency ground ambulance • Stretcher vans • Wheelchair vans • Public bus • Volunteer / registered drivers • Taxi cabs	$0 copay *Prior authorization and/or referral may be required
Urgently needed care *Urgently needed care* is care given to treat: • a non-emergency, ***or*** • a sudden medical illness, ***or*** • an injury, ***or*** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. You are covered for urgently needed care in the United States and its territories.	$0 copay

Services that our plan pays for	What you must pay
Vision care The plan covers the following: • Routine eye exams which includes refraction, up to one per year • Eye glasses (lenses and frames) limited to one pair per year • Contact lenses limited to one pair per year • $100 maximum benefit coverage amount for contacts, eyeglasses-lenses and frames per year The plan will also pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, and • African-Americans who are age 50 and older. • Hispanic Americans who are 65 or older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)	$0 copay
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), and • referrals for other care if you need it. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 copay
Wellness visit The plan covers wellness checkups to make or update a prevention plan.	$0 copay

E. Benefits covered outside of Humana Gold Plus Integrated

The following services are not covered by Humana Gold Plus Integrated but are available through Medicare or Medicaid.

Hospice care

If you choose to enroll in a hospice program, you will be disenrolled from Humana Gold Plus Integrated and get all of your medical care and services through standard Medicare and Medicaid. You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

Targeted Case Management Services

You may also get Targeted Case Management (TCM) services directly from the Virginia Department of Medical Assistance Services. TCM offers assistance to individuals with serious mental illness in accessing needed medical, psychiatric, social, educational, vocational and other supports essential to meeting basic needs. You can contact your local community services board for more information about TCM.

Case Management Services for Participants of Auxiliary Grants

This is an income supplement for individuals who get Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals who reside in a licensed assisted living facility (ALF) or an approved adult foster care (AFC) home.

Certain Dental Services (unless otherwise noted)

Humana Gold Plus Integrated is responsible for some medically necessary procedures. Call Customer Care at the number at the bottom of the page for more information.

F. Benefits *not* covered by Humana Gold Plus Integrated, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not pay for these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section 4, page 124.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See page 37 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- A private room in a hospital, except when it is medically needed.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Homemaker services, including basic household assistance, light cleaning or making meals.
- Fees charged by your immediate relatives or members of your household
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Medications for erectile dysfunction.
- Acupuncture.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids. However, the plan will pay for glasses after cataract surgery.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.

- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost-sharing amounts.

Chapter 5: Getting your outpatient prescription drugs through the plan

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Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid. Chapter 6, Section C, page 94 tells you what you pay for these drugs.

Humana Gold Plus Integrated also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D, page 60.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception. See Section D, page 86 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication*. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➤ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care at the number at the bottom of the page or your care manager.

Show your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for our share of the cost of your covered prescription drug. You will need to pay the pharmacy a copay when you pick up your prescription.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up*. You can then ask us to pay you back for our share. If you cannot pay for the drug, contact Customer Care at the number at the bottom of the page right away. We will do what we can to help.

➤ To learn how to ask us to pay you back, see Chapter 7, Section A, page 100.

➤ If you need help getting a prescription filled, you can contact Customer Care at the number at the bottom of the page or your care manager.

What if you want to change to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

➤ If you need help changing your network pharmacy, you can contact Customer Care at the number at the bottom of the page or your care manager.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➤ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care at the number at the bottom of the page or your care manager.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy*. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy. If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Customer Care at the number at the bottom of the page.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➤ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care at the number at the bottom of the page or your care manager.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service allows you to order up to a 90-day supply of your prescription drugs. A 90-day supply has the same copay as a three-month supply.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, call Customer Care at the number at the bottom of the page.

Usually, a mail-order prescription will get to you within 14 days. We recommend that you discuss with your physician the option of writing a prescription for a 30-day supply to fill at a network retail pharmacy along with your prescription for mail-order, in case your order is delayed.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy gets from you**

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets directly from your provider's office**

   The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

   - You used mail order services with this plan in the past, or
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling Customer Care at the number at the bottom of the page.

If you get a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Customer Care at the number at the bottom of the page.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, please contact us by calling Customer Care at the number at the bottom of the page.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can call Customer Care at the number at the bottom of the page.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a three-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Customer Care the number at the bottom of the page for more information.

You can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If the prescriptions are connected with emergency care that the plan pays for
- If the prescriptions are connected with urgently needed care that the plan pays for when you cannot get to a network provider
- If you are in a declared disaster area and need to refill your prescription

➤ In these cases, please check first with Customer Care at the number at the bottom of the page to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

➤ To learn more about this, see Chapter 7, Section A, page 100.

B. The plan's Drug List

The plan has a *List of Covered Drugs*. We call it the *"Drug List"* for short.

The drugs on the *Drug List* are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's *Drug List* as long as you follow the rules explained in this chapter.

What is on the Drug List?

The *Drug List* includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and items covered under your Medicaid benefits.

The *Drug List* includes both brand-name and *generic* drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's *Drug List* as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products when they are written as a prescription by your provider. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Customer Care at the number at the bottom of the page.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the *Drug List*, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at **Humana.com.** The *Drug List* on the website is always the most current one.
- Call Customer Care at the number at the bottom of the page to find out if a drug is on the plan's *Drug List* or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the *Drug List* because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the *Drug List.*

Humana Gold Plus Integrated will *not* pay for the drugs listed in this section. These are called *excluded drugs*. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, Section 4, page 124).

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Humana Gold Plus Integrated for free, but they are not considered part of your outpatient prescription drug benefits.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use*. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are cost-sharing tiers?

Every drug on the plan's *Drug List* is in one of four cost-sharing tiers. A tier is a group of drugs generally the same type (for example, brand name, generic, or over-the-counter drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Cost-Sharing Tier 1 – Generics
- Cost-Sharing Tier 2 – Brands

- Cost-Sharing Tier 3 – Non-Medicare Rx Drugs (CMS excluded drugs that are covered by Medicaid)
- Cost-Sharing Tier 4 – Non-Medicare OTC

To find out which cost-sharing tier your drug is in, look for the drug in the plan's *Drug List*.

➤ Chapter 6, Section C, page 94 tells the amount you pay for drugs in each cost-sharing tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➤ To learn more about asking for exceptions, see Chapter 9, Section 6, page 137.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, if there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that the generic drug will not work for you ***or*** has written "No substitutions" on your prescription for a brand-name drug ***or*** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. Your copay may be greater for the brand-name drug than for the generic drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Humana Gold Plus Integrated before you fill your prescription. If you don't get approval, Humana Gold Plus Integrated may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription. Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the *Drug List*. For the most up-to-date information, call Customer Care at the number at the bottom of the page or check our website at **Humana.com**.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan**. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug**. As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the *Drug List* or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. **The drug you have been taking:**
   - is no longer on the plan's *Drug List*, ***or***
   - was never on the plan's *Drug List*, ***or***
   - is now limited in some way.
2. **You must be in one of these situations:**
   - **You were in the plan last year and do not live in a long-term care facility.**

     We will cover a temporary supply of your drug during the first 90 days of the calendar year. This temporary supply will be for up to 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30-day supply of medication. You must fill the prescription at a network pharmacy.
   - **You are new to the plan and do not live in a long-term care facility.**

     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan. This temporary supply will be for up to a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. You must fill the prescription at a network pharmacy.
   - **You were in the plan last year and live in a long-term care facility.**

     We will cover a temporary supply of your drug during the first 90 days of the calendar year. The total supply will be for up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
   - **You are new to the plan and live in a long-term care facility.**

     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan. The total supply will be for up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

  Transition Supply for Current Members with changes in treatment setting:

  Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:

- Members who are discharged from a hospital or skilled nursing facility to a home setting
- Members who are admitted to a hospital or skilled nursing facility from a home setting
- Members who transfer from one skilled nursing facility to another and are served by a different pharmacy
- Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit
- Members who give up hospice status and revert back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

➤ To ask for a temporary supply of a drug, call Customer Care at the number at the bottom of the page.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

  There may be a different drug covered by the plan that works for you. You can call Customer Care at the number at the bottom of the page to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

➤ To learn more about asking for an exception, see Chapter 9, Section 6.2, page 138.

If you need help asking for an exception, you can contact Customer Care at the number at the bottom of the page or your care manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We move your drug into a higher cost-sharing tier.
- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, Section 6.2, page 138.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➤ If there is a change to coverage for a drug you are taking, **the plan will send you a notice**. Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

➤ To learn more about drug coverage and what you pay, see Chapter 6, Section C, page 94.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Customer Care at the number at the bottom of the page.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our *Drug List* or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership, until we have given you a 98-day supply. The first supply will be for up to 31 days, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➤ To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 138.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

- If you have any questions about these programs, please contact Customer Care at the number at the bottom of the page or your care manager.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

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Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Medicaid, ***and***
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medicaid, you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **The plan's *List of Covered Drugs***. We call this the *"Drug List."* It tells you:
  - Which drugs the plan pays for
  - Which of the four cost-sharing tiers each drug is in
  - Whether there are any limits on the drugs

  If you need a copy of the *Drug List*, call Customer Care at the number at the bottom of the page. You can also find the Drug List on our website at **Humana.com.** The *Drug List* on the website is always the most current.
- **Chapter 5 of this Member Handbook**. Chapter 5, Section Introduction, page 80 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **The plan's *Provider and Pharmacy Directory***. In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 80.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your *out-of-pocket costs*. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your *total drug costs*. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits*. We call it the *EOB* for short. The *EOB* includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information**. This is your total drug costs and the total payments made since January 1.

➤ We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your total out-of-pocket costs. To find out which drugs our plan covers, see the *Drug List*.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to pay you back for our share of the cost of the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

➤ To learn how to ask us to pay you back for our share of the cost of the drug, see Chapter 7, Section B, page 101.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a state pharmaceutical assistance program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, Humana Gold Plus Integrated pays all of the costs of your Part D drugs for the rest of the year.

4. Check the reports we send you.

When you get an *Explanation of Benefits* in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Customer Care at the number at the bottom of the page. Be sure to keep these reports. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under Humana Gold Plus Integrated. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	**Stage 2:** Catastrophic Coverage Stage
During this stage, **the plan pays part of the costs** of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, **the plan pays all of the costs** of your drugs through December 31, 2017. You begin this stage when you have paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it.

The plan's cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's *Drug List* is in one of four cost-sharing tiers. To find the cost-sharing tiers for your drugs, you can look in the *Drug List*.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from $0 to $3.30, depending on your income.
- Tier 2 drugs have a medium copay. They are brand name drugs. The copay is from $0 to $8.25, depending on your income.
- Tier 3 drugs have a copay of $0.
- Tier 4 drugs have a copay of $0.

You'll need a prescription from your provider for any drug covered on our drug list no matter which tier it is on.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, ***or***
- an out-of-network pharmacy.

➤ In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5, Section A, page 80 to find out when we will do that.

➤ To learn more about these pharmacy choices, see Chapter 5, Section A, page 80 in this handbook and the plan's *Provider and Pharmacy Directory*.

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a three-month supply.

➤ For details on where and how to get a long-term supply of a drug, see Chapter 5, Section A, page 80 or the *Provider and Pharmacy Directory*.

How much do you pay?

During the Initial Coverage Stage, you will pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

➤ You can contact Customer Care at the number at the bottom of the page to find out how much your copay is for any covered drug.

Your share of the cost when you get a *one-month* supply of a covered prescription drug from:

	A network pharmacy A one-month supply or up to a 31-day supply	**A network long-term care pharmacy** A one-month supply or up to a 31-day supply	**An out-of-network pharmacy** A one-month supply or up to a 31-day supply
Cost-Sharing Tier 1 (Generics)	$0 or up to $3.30	$0	$0 or up to $3.30
Cost-Sharing Tier 2 (Brands)	$0 or up to $8.25	$0	$0 or up to $8.25
Cost-Sharing Tier 3 (Non-Medicare Rx Drugs)	$0	$0	$0
Cost-Sharing Tier 4 (Non-Medicare OTC)	$0	$0	$0

Your share of the cost when you get a *long-term* supply of a covered prescription drug from:

	A network pharmacy A three-month or up to a 90-day supply	**The plan's mail order service** A three-month or up to a 90-day supply
Cost-Sharing Tier 1 (Generics)	$0 or up to $9.90	$0 or up to $9.90
Cost-Sharing Tier 2 (Brands)	$0 or up to $24.75	$0 or up to $24.75
Cost-Sharing Tier 3 (Non-Medicare Rx Drugs)	$0	$0
Cost-Sharing Tier 4 (Non-Medicare OTC)	$0	$0

- For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory*.
- Copays for prescription drugs may vary based on the level of Extra Help the member gets.

When does the Initial Coverage Stage end?

The Initial Coverage Stage ends when your total out-of-pocket costs reach $4,950. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Your Explanation of Benefits reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $4,950 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $4,950 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

In some cases, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, your copay will be based on the number of days of the drug that you get. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.20. This means that the amount you pay per day for your drug is $0.04. If you get a 7 days' supply of the drug, your payment will be $0.04 per day multiplied by 7 days, for a total payment of $0.28.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you better plan when to refill your drugs and take fewer trips to the pharmacy. The amount you pay will depend on the days' supply you get.

G. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

Before you get a vaccination

We recommend that you call us first at Customer Care at the number at the bottom of the page whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Humana Gold Plus Integrated to ensure that you do not have any upfront costs for a Part D vaccine.

How much you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4, Section D, page 42.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccination at your doctor's office and the doctor gives you the shot.
   - You will pay a copay to the doctor for the vaccine.
   - Our plan will pay for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
    - You will pay a copay for the vaccine.
    - Our plan will pay for the cost of giving you the shot.

If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself and for getting the shot. If you are in this situation, we recommend that you call us first at Customer Care at the number at the bottom of the page. You can also ask the provider to call Humana Gold Plus Integrated before you get your vaccine. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back for our share of the cost.

To learn how to ask us to pay you back, see Chapter 7, Section B, page 101.

Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs

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A. When you can ask us to pay for your services or drugs

Our network providers must bill the plan for your services and drugs you already got. A *network provider* is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, see page 101.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid more than your share of the cost, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

➤ Contact Customer Care at the number at the bottom of the page or your care manager if you have any questions. If you do not know what you should have paid, or if you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill the plan.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
  - ➤ If the provider should be paid, we will pay the provider directly.
  - ➤ If you have already paid more than your share of the cost for the service, we will figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill the plan.

- We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, but you feel that you paid too much, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

➤ In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost. Please see Chapter 5, Section A, page 80 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision see Chapter 9, Section 4, page 124.
  - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9, Section 6.4, page 140).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

➤ To learn how to make an appeal, see Chapter 9, Section 6.1, page 137.

B. How and where to send us your request for payment

If you experience a situation where for some reason you pay for your pharmacy claim that you think should have been covered by your drug benefit, you can submit a request for reimbursement from Humana Gold Plus Integrated.

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your care manager for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (https://www.**Humana.com**/medicare/pharmacy/tools/medicare-drug-list/), or you can call Customer Care at the number at the bottom of the page and ask for the form.

Mail your request for payment together with any bills or receipts to us at this address:

Humana Pharmacy Solutions
P.O. Box 14140
Lexington, KY 40512-4140
Or Fax to 1-866-754-5362

You must submit your claim to us by three months after the end of the year in which you got the service, item, or drug.

C. We will make a coverage decision

When we get your request for payment, we will make a *coverage decision*. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the service or drug, we will mail you a check for our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.

➤ Chapter 3, Section B, page 26 explains the rules for getting your services covered. Chapter 5, Introduction Section, page 80 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

➤ To learn more about coverage decisions, see Chapter 9, Section 4, page 124.

D. You can make an appeal

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called *making an appeal*. You can also make an appeal if you do not agree with the amount we pay.

➤ The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9, Section 4, page 124.

- If you want to make an appeal about getting paid back for a health care service, go to Chapter 9, Section 5.5, page 136.
- If you want to make an appeal about getting paid back for a drug, go to Chapter 9, Section 6.1, page 137.

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. You are free to exercise these rights, and the exercise of these rights will not negatively affect the way you are treated.

A. You have a right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Customer Care at the number at the bottom of the page. Our plan has people who can answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. You can make a STANDING REQUEST to receive materials, now and in the future, in a language other than English or in an alternate format by calling Customer Care at the number at the bottom of the page. To get information in a way that you can understand, call Customer Care. Our plan has people who can answer questions in different languages. Spanish materials are available upon request. For assistance with other languages you can contact our free interpreter services at the Customer Care number at the bottom of the page.
- If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can also file a complaint with Medicaid by calling 804-786-6145. TTY users should call 1-800-343-0634.

B. We must treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Age
- Appeals
- Behavior
- Claims experience
- Ethnicity
- Evidence of insurability
- Gender identity
- Genetic information
- Geographic location within the service area
- Health status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.

We cannot deny services to you or prevent you from exercising your rights.

- For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697).
- You can also call your local Office for Civil Rights:
  Office of Civil Rights
  U.S. Department of Health and Human Services
  150 S. Independence Mall West, Suite 372
  Public Ledger Building
  Philadelphia, PA 19106-9111
  Toll Free: 1-800-368-1019
  TDD 1-800-537-7697
- If you have a disability and need help accessing care or a provider, call Customer Care at the number at the bottom of the page. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

C. We must ensure that you get timely access to covered services and drugs

If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A *network provider* is a provider who works with the health plan.
  - Call Customer Care or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a gynecologist or another women's health specialist without getting a referral. A *referral* is a written order from your primary care provider.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, Section D, page 28.

Chapter 9, Section 10, page 157 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section 5.3, page 129 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on our quality of care.
  - We are required to give Medicare and Medicaid your health and drug information. If Medicare or Medicaid releases your information for research or other uses, it will be done according to any applicable Federal and/or state laws.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Customer Care at the number at the bottom of the page.

Notice of Privacy Practices
For your personal health information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How do we use and disclose your information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments

- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application or insurance. (This right applies only to our Massachusetts residents in accordance with state regulations.)
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of that are made to me?

- Appointment reminders

- Treatment alternatives or other health-related benefits or services
- Fundraising activities

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@**Humana.com**
- Send completed request form to:

  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater member protection.

What will happen if my private information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company

CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
Corphealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Behavioral Health
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

E. We must give you information about the plan, its network providers, and your covered services

As a member of Humana Gold Plus Integrated, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. This is a free service. Spanish materials are available upon request. For assistance with other languages, you can contact our free interpreter services at the number above. We can also give you information in large print, braille, or audio. You can request alternate formats by calling Customer Care at the number at the bottom of the page.

If you want any of the following, call Customer Care at the number at the bottom of the page:

- **Information about how to choose or change plans**
- **Information about our plan, including:**
  - Financial information
  - How the plan has been rated by plan members
  - The number of appeals made by members
  - How to leave the plan
- **Information about our network providers and our network pharmacies, including:**
  - How to choose or change primary care providers
  - The qualifications of our network providers and pharmacies
  - How we pay the providers in our network
    - ➤ For a list of providers and pharmacies in the plan's network, see the P*rovider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Customer Care at the number at the bottom of the page, or visit our website at **Humana.com.**
- **Information about covered services and drugs and about rules you must follow, including:**
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- **Information about why something is not covered and what you can do about it, including:**
  - Asking us to put in writing why something is not covered
  - Asking us to change a decision we made
  - Asking us to pay for a bill you got

Coverage of new medical procedures and devices:

Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan decides about coverage of new medical procedures and devices on an ongoing basis. This is done by checking peer-reviewed medical literature and consulting with medical experts to see if the new technology is effective and safe. We also relies on guidance from the Centers for Medicare & Medicaid Services (CMS), which often makes national coverage decisions for new medical procedures or devices.

Utilization Management (UM):

Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan wants you to get the right medical care from the right provider at the right time. To make sure of this, we work with your doctors and hospital to make sure the number of days you stay in the hospital and the services you get are medically needed and right for your medical condition.

It is important to understand that:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in under utilization.

Humana Gold Plus Integrated (Medicare-Medicaid Plan) plan has people and free language interpreter services available to answer questions related to UM from non-English speaking members. Contact Customer Care at the number at the bottom of the page.

Quality Improvement (QI) Program:

Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan wants to provide you with quality care so we have developed a program to make sure we are always improving. This is called the Quality Improvement (QI) program. Humana's Quality Improvement Program includes clinical care, preventive care and member services. It is available on Humana's website under Member Guidelines/Important Member Information. To request a printed copy, call Customer Care at the number at the bottom of the page or write to us at: Humana Quality Operations and Compliance Department, QI Program, 321 West Main, WFP 20, Louisville, KY 40202.

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, Section B, page 101.

G. You have the right to leave the plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. Your membership will end on the last day of the month that you ask to change your plan. If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your

Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. You can get your Medicaid services through any enrolled Medicaid provider.

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **You can say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You can ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section 6.1, page 137 tells how to ask the plan for a coverage decision.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive*. There are different types of advance directives and different names for them. Examples are a *living will and a power of attorney for health care*.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get the Virginia Advance Directive form at http://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf. You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid *(local Department of Social Services, Area Agencies on Aging (AAA), Virginia*

Department for Aging and Rehabilitative Services (DARS), and Virginia Centers for Independent Living) may also have advance directive forms. You can also contact Customer Care to ask for the forms.

- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Toll-Free Phone: 1-800-533-1560 Local Phone: 804-367-4691
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
FAX	804-527-4424
EMAIL	enfcomplaints@dhp.virginia.gov
WEBSITE	http://www.dhp.virginia.gov/Enforcement/complaints.htm

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and managed care organizations, contact the Office of Licensure and Certification at the Virginia Department of Health:

CALL	Toll-Free Phone: 1-800-955-1819 Local Phone: 804-367-2106
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1463
FAX	804-527-4503
EMAIL	OLC-Complaints@vdh.virginia.gov
WEBSITE	http://www.vdh.state.va.us/olc/complaint/

I. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section 1, page 122 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Customer Care at the number at the bottom of the page.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is not about discrimination for the reasons listed on page 104—you can get help in these ways:

- You can **call Customer Care**.
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see Chapter 2, Section E, page 19.
- You can **call the Commonwealth Coordinated Care Ombudsman.** For details about this organization and how to contact it, see Chapter 2, Section I, page 22.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can call **Customer Care**.

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see Chapter 2, Section E, page 19.
- You can **call the Commonwealth Coordinated Care Ombudsman.** For details about this organization and how to contact it, see Chapter 2, Section I, page 22.
- You can **contact Medicare**.
  - You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

J. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Customer Care at the number at the bottom of the page.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
  - For details about your covered services, see Chapter 3, Section A, page 26 and Chapter 4, Section D, page 42 Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - For details about your covered drugs, see Chapter 5, Section B, page 83 and Chapter 6, Section Introduction, page 92.
- **Tell us about any other health or prescription drug coverage you have.** We are required to make sure that you are using all of your coverage options when you get health care. Please call Customer Care at the number at the bottom of the page if you have other coverage.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your Member ID Card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Humana Gold Plus Integrated members, Medicaid pays for your Part A premium and for your Part B premium.
  - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copay (a fixed amount). Chapter 6, Section C, page 94 tells what you must pay for your drugs.
  - If you get any services or drugs that are not covered by our plan, you must pay the full cost.
  - If you have a patient pay for your nursing facility or Elderly or Disabled with Consumer Direction (EDCD) Waiver services, you must pay the designated provider the patient pay each month. If you do not make your patient pay, you may lose your services.

➤ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Section 6.5, page 142 to learn how to make an appeal.

- **Notify your eligibility worker at the Local Department of Social Services of any change in income, bonuses received, inheritance, etc.**
  - The Virginia Department of Medical Assistance Services pays a monthly premium to Humana Gold Plus Integrated for your coverage. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your eligibility worker, you may have to repay the monthly premiums, even if you received no medical services during those months.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Customer Care at the number at the bottom of the page.
  - **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1, Section D, page 6 tells about our service area. We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2, Section G, page 21 for phone numbers for Medicare and Medicaid.
  - **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call Customer Care at the number at the bottom of the page for help for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.**

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950)**. This chapter will explain the different options you have for different problems and complaints, but you can always call the ombudsman office to help guide you through your problem.

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Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination" or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Commonwealth Coordinated Care Ombudsman

If you need help, you can always call the Commonwealth Coordinated Care Ombudsman. This office can answer your questions and help you understand what to do to handle your problem. This office is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Commonwealth Coordinated Care Ombudsman is 1-800-552-5019 (TTY: 1-800-464-9950). The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Virginia, this program is called the Virginia Insurance Counseling and Assistance Program (VICAP). VICAP counselors can answer your questions and help you understand what to do to handle your problem. VICAP is not connected with us or with any

insurance company or health plan. The VICAP has trained counselors, and services are free. The VICAP phone number is 1-800-552-3402.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from Medicaid

If you have questions about the help you get from Medicaid, you can contact the Department of Medical Assistance Services (DMAS):

- Call 804-786-6145 from 8:00 am to 5:00 p.m. TTY users should call 1-800-343-0634.
- Visit the DMAS website at http://www.dmas.virginia.gov.

Section 3: Problems with your Benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go to the next section of this chapter, **Section 4, "Coverage decisions and appeals"** on page 124.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint"** on page 157.

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision **before** the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Customer Care** at the number at the bottom of the page. You can ask us for information about filing a complaint or appeal, ask us to send you complaint or appeal forms, or ask for help completing the forms. We can also provide interpreter services that you may need for the complaint or appeal process.
- Call the **Commonwealth Coordinated Care Ombudsman** for free help. The Commonwealth Coordinated Care Ombudsman can help you with service or billing problems. The phone number is 1-800-552-5019.
- Call the **Office of the State Long-Term Care Ombudsman** for free help. The Office of the State Long-Term Care Ombudsman helps people receiving long-term care services. The phone number is 1-800-552-3402.
- Call the **Virginia Insurance Counseling and Assistance Program (VICAP)** for free help. The VICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-552-3402.
- Talk to **your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or other person to be your representative, call Customer Care and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **https://www.humana.com/individual-and-family-support/tools/member-forms**. The form will give the person permission to act for you. You must give us a copy of the signed form.

- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5** on page 126 gives you information if you have problems about services, items, and drugs (but not Part D drugs). For example, use this section if:

  - You are not getting medical care you want, and you believe that this care is covered by our plan.

  - We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered.

    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with an over-the-counter (OTC) are not covered by Part D. See Section 6 for Part D drug appeals.

  - You got medical care or services that you think should be covered, but we are not paying for this care.

  - You got and paid for services or items you thought were covered, and you want to ask us to pay you back.

  - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

    - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 145 and 151.

- **Section 6** on page 137 gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7** on page 145 gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8** on page 151 gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Customer Care at the number at the bottom of the page.

If you need other help or information, please call the Commonwealth Coordinated Care Ombudsman by calling 1-800-552-5019 (TTY: 1-800-464-9950).

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with an over-the-counter (OTC) are not covered by Part D. Use Section 6 for Part D drug Appeals.

This section tells what you can do if you are in any of the five following situations:

1. **You think we cover a medical, behavioral health or long-term care service that you need but are not getting.**

   What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 127 for information on asking for a coverage decision.

2. **We did not approve care your doctor wants to give you, and you think we should have.**

   What you can do: You can appeal our decision to not approve the care. Go to Section 5.3 on page 129 for information on making an appeal.

3. **You got services or items that you think we cover, but we will not pay.**

   What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 129 for information on making an appeal.

4. **You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.**

   What you can do: You can ask us to pay you back. Go to Section 5.5 on page 136 for information on asking us for payment.

5. **We reduced or stopped your coverage for a certain service, and you disagree with our decision.**

   What you can do: You can appeal our decision to reduce or stop the service. Go to Section 5.3 on page 129 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 145-155 to find out more.

Section 5.2: Asking for a Coverage Decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-855-280-4002 TTY: 711.
- You can fax us at: 1-800-266-3022
- You can write to us at: Humana P.O. Box 14168, Lexington, KY 40512-4168

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked. If we don't give you our decision within 14 calendar days, you can appeal.

➤ Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more days. The letter will explain why more time is needed.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 72 hours.**

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

The legal term for *"fast coverage decision"* is ***"expedited determination."***

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling, writing, or faxing our plan to ask us to cover the care you want.
- You can call us at 1-866-737-5113 (TTY: 711) or fax us at 1-855-336-6220. For details on how to contact us, go to Chapter 2 page 14
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you have already got.)
2. You can get a fast coverage decision *only* if the standard 14 day deadline could *cause serious harm to your health or hurt your ability to function*.
   - **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
   - If you ask for a fast coverage decision, without your doctor's support, we will decide if you get a fast coverage decision.
     - ➤ If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline instead.
     - ➤ This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
     - ➤ The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 on page 157 of this chapter.)

If the coverage decision is *Yes*, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying *No*.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950). The Commonwealth Coordinated Care Ombudsman is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, you have fewer days to appeal if you want to keep getting that service while your appeal is processing.

➤ Keep reading this section to learn about what deadline applies to your appeal.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at the number at the bottom of the page. For additional details on how to reach us for appeals, see Chapter 2, page 15.

- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - You can submit a request to the following address:
    Humana Inc.
    Attn: Grievances and Appeals
    PO Box 14546
    Lexington, KY 40512-4546
  - You may also ask for an appeal by calling us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

The legal term for *"fast appeal"* is ***"expedited reconsideration."***

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Customer Care and ask for one, or visit the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at **https://www.humana.com/individual-and-family-support/tools/member-forms**.

➤ If the appeal comes from someone besides you, we usually must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 132 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Customer Care at the number at the bottom of the page.

➤ We are allowed to charge a fee for copying and sending this information to you.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 157.

- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a Medicare service or item. You will be notified when this happens. If your problem is about a Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 132.

- **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 30 days after we get your appeal.

- **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 132.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 159.

- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a Medicare service or item. You will be notified when this happens. If your problem is about a Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 132 of this chapter.

➢ **If our answer is *Yes*** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

➢ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 on page 132 of this chapter.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking action. If you disagree with the action and want to appeal, you can keep getting the service while your appeal is being reviewed. In order to qualify, you must **ask for an appeal within 10 days of the date of the notice of action or before the service is stopped or reduced**, whichever is later. If you lose your appeal, you may have to pay for those services.

Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says *No* at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.

- If your problem is about a **Medicaid** service or item, you can file a Level 2 Appeal yourself with the Department of Medical Assistance Services (DMAS). The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. You can also file a Level 2 Appeal yourself with DMAS.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. It is either the Independent Review Entity (IRE) or it is the Department of Medical Assistance Services (DMAS).

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

To file a Level 2 Appeal about a Medicaid service or item, you, your doctor or other provider, or your representative must send a written appeal request to the Department of Medical Assistance Services (DMAS) **within 60 calendar days** from the date on the letter we sent to tell you our decision. You may write a letter or complete an Appeal Request Form. The form is available at your local Department of Social Services or on the internet at http://www.dmas.virginia.gov/Content_atchs/forms/dmas-200.pdf. You can also call 804-371-8488 to ask for the form.

You must send DMAS a copy of the letter we sent to you. You must sign the appeal request and send it to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 11th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to 804-612-0036.

If you want your Level 2 Appeal to be a fast appeal, you must write that on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need a fast appeal. DMAS will tell you if you qualify for a fast appeal within three business days of receiving the letter from your doctor.

If you qualify for a fast appeal, DMAS will also give you an answer to your appeal within three business days of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within three business days. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for fast decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within three business days of receiving your doctor's letter.

If your Level 2 Appeal is not a fast appeal, or if DMAS decides that you do not qualify for a fast appeal. DMAS will give you an answer within 30 calendar days of when it gets your appeal. You will have an opportunity to participate in a hearing to present your position before a decision is made.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Customer Care at the phone number at the bottom of this page. We are allowed to charge you a fee for copying and sending this information to you.

➤ The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

– However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➤ If you had "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The review organization must give you an answer within 72 hours of when it gets your appeal.

– However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also submit a Level 2 Appeal to DMAS. Follow the instructions on page 134.

Will my benefits continue during Level 2 appeals?

If your problem is about a service or item covered by Medicare only, your benefits for that service or item will not continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medicaid or both Medicare and Medicaid, your benefits for that service or item will continue during the Level 2 appeals process if:

- You or your doctor or other provider sends a Level 2 Appeal to the Department of Medical Assistance Services (DMAS) within 10 days of the date on our Level 1 decision letter.
- Your appeal is about our decision to stop, suspend or reduce a course of treatment that was already preauthorized.
- The service or item was ordered by an authorized provider.
- The timeframe covered by the preauthorization has not passed.
- You request that your benefits be continued. To ask for a continuation of your benefits, call DMAS at 804-786-6145. TTY users should call 1-800-343-0634.

While the Level 2 Appeal is pending with DMAS, your benefits will continue until:

- You withdraw the appeal, or
- The timeframe of the preauthorization has been met, or
- The service limit of the preauthorization has been met, or
- The DMAS hearing officer upholds our original decision.

If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services or items, we may take back the money that was paid for the services or items while the appeal was in process.

How will I find out about the decision?

If your Level 2 Appeal went to DMAS, it will send you a letter explaining its decision.

- If DMAS says ***Yes*** to part or all of what you asked for, we must authorize the medical care coverage within 72 hours from the date we received your appeal decision from DMAS.
- If DMAS says ***No*** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says ***Yes*** to part or all of what you asked for, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we receive the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says ***No*** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I appealed to both the IRE and DMAS and they have different decisions?

If either the IRE or DMAS decides ***Yes*** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is *No* for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal went to DMAS, you can appeal again. The letter you get from DMAS will tell you how to make another appeal.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

See Section 9 on page 156 for more information on additional levels of appeal.

Section 5.5: Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. If a provider bills you for any charges that we did not pay, that is called "balance billing." You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for tier 1 and tier 2 drugs.

If you get a bill that is more than your copay for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: *Asking us to pay our share of a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for your share of a service or item I paid for?

Remember, if you get a bill that is more than your copay for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of the service or item within 60 calendar days after we get your request.

  Or, if you haven't paid for the services or items yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

- If the service or item is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal.** Follow the appeals process described in Section 5.3 on page 129. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for medical care you have already got and paid for yourself, you cannot ask for a fast appeal.

➤ If we answer ***No*** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is ***Yes*** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.

- If the IRE says ***No*** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page 156 for more information on additional levels of appeal.

➤ If we answer ***No*** to your appeal and the service or item is usually covered by Medicaid, you can file a Level 2 Appeal yourself (see Section 5.4 of this chapter on page 132).

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals**.

- The L*ist of Covered Drugs (Drug List)*, includes some drugs with a (OTC). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with (OTC) symbol follow the process in **Section 5 on page 126**.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).
  - **NOTE**: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

The legal term for a *coverage decision* about your Part D drugs is ***"coverage determination."***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** on page 138 of this chapter. Also see Sections 6.3 and 6.4. on pages 139 and 140.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** on page 140.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** on page 140.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** on page 142.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
    - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 2. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, page 85).

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - Quantity limits. For some drugs, the plan limits the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

The legal term *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells on page 142 how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

***At a glance:* How to ask for a Coverage Decision about a drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➤ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

Read Section 4 on page 124 to find out how to give permission to someone else to act as your representative.

➤ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

- If you want to ask us to pay you back for a drug, read Chapter 7, Section B, page 101 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- If you are asking for an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."

  Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.

- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

  - If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.

    If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead. We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 157.

The legal term for *"fast coverage decision"* is ***"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➢ **If our answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

➢ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said ***No***. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➤ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

➤ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said ***No***. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.

➤ **If our answer is *Yes*** to part or all of what you asked for, we will make payment to you within 14 calendar days.

➤ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-280-4002 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **Humana.com** for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➤ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want a fast appeal, you may make your appeal in writing or you may call us.

- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

The legal term *for an appeal to the plan about a Plan D drug coverage decision is plan* ***"redetermination."***

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Customer Care at the phone number at the bottom of this page. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 on page 140.

The legal term for *"fast appeal"* is ***"expedited reconsideration."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said ***No*** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➢ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➢ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said ***No***.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."

- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➤ **If our answer is *Yes*** to part or all of what you asked for:

  – If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

  – If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➤ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said ***No*** and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say ***No*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.

- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Customer Care at the phone number at the bottom of this page. We are allowed to charge you a fee for copying and sending this information to you.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.

- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➤ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have a right to give the IRE other information to support your appeal.

- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.

- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The legal term *for an appeal to the IRE about a Part D drug is* ***reconsideration.***

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says ***Yes*** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the IRE must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - If the IRE says ***Yes*** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights*. If you do not get this notice, ask any hospital employee for it. If you need help, please call Customer Care at the phone number at the bottom of this page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including your rights to:

- get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- be a part of any decisions about the length of your hospital stay.
- know where to report any concerns you have about the quality of your hospital care.
- appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Customer Care at the number at the bottom of the page. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also see the notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

➤ If you need help, please call Customer Care at at the number at the bottom of the page or Medicare at the numbers listed above.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you. In Virginia, the Quality Improvement Organization is called KEPRO.

To make an appeal to change your discharge date call the KEPRO at: **1-844-455-8708 (TTY: 1-855-843-4776)**

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.

- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

➤ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 149.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care the number at the bottom of the page. You can also call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. Or, you can call the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950).

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a "**fast review**" of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term** for "fast review" is **"immediate review."

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.

- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term *for this written explanation is called the* ***"Detailed Notice of Discharge."*** *You can get a sample by calling Customer Care at* **1-855-280-4002** (TTY: 711). *You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html*

What if the answer is *Yes*?

- If the Quality Improvement Organization says ***Yes*** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the Quality Improvement Organization says ***No*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.

- If the Quality Improvement Organization says ***No*** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.

- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Virginia, the Quality Improvement Organization is called KEPRO. You can reach the KEPRO at: **1-844-455-8708 (TTY: 1-855-843-4776).**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

What happens if the answer is *Yes?*

- We must pay you back for our share of the costs of hospital care you have got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No?*

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

***At a glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-844-455-8708 (TTY: 1-855-843-4776) and ask for another review.

Section 7.4: What happens if I miss an Appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Customer Care number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  – If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➤ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 157 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said ***No*** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.

At a glance: **How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- If the IRE says ***Yes*** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If the IRE says ***No*** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - ➤ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - ➤ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the *Notice of Medicare Non-Coverage*.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying our share of the cost for your care.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 on page 157 tells you how to file a complaint.)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care the number at the bottom of the page. Or call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Virginia, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-844-455-8708 (TTY: 1-855-843-4776). Information about appealing to the Quality Improvement Organization is also in the *Notice of Medicare Non-Coverage*. This is the notice you got when you were told we would stop covering your care.

***At a glance:* How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization for your state at 1-844-455-8708 (TTY: 1-855-843-4776) and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4. on page 154.

The legal term *for the written notice is "Notice of Medicare Non-Coverage."*
To get a sample copy, call Customer Care at 1-855-280-4002 (TTY: 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.).
Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say Yes?

- If the reviewers say ***Yes*** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No?*

- If the reviewers say ***No*** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said ***No*** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

In Virginia, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-844-455-8708.

At a glance: **How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said ***No*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says *Yes?*

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No?*

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Customer Care number and ask for a "fast review."

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say *No* to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

- If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➤ To make sure we were following all the rules when we said ***No*** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 157 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **IRE** reviews the decision we made when we said ***No*** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says *Yes*** to your appeal, then we must pay you back for our share of the costs of care. We must also continue the plan's coverage of your services for as long as it is medically necessary.

At a glance: **How to make a Level 2 Appeal to require that the plan continue your care**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Organization.

- **If the IRE says *No*** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950).

Section 9.2: Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid.

You can ask to appeal the DMAS hearing officer's decision if you do not agree with it. You must follow a two-step process as provided by Rules 2A:2 and 2A:4 of the Rules of the Supreme Court of Virginia.

- First you must file a Notice of Appeal with the director of DMAS within 30 days from the date you receive the hearing officer's decision.
- Next, you must file a Petition for Appeal in your local Circuit Court within 30 days after you file your Notice of Appeal with the DMAS director.
- The first level of court review is Circuit Court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court.

The letter you get with the appeal decision and the copy of Rules 2A:2 and 2A:4 of the Rules of the Supreme Court of Virginia will give you information about appealing to the Circuit Court.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only*, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential*.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Humana Gold Plus Integrated staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Customer Care or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

***At a glance:* How to make a complaint**

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section 10.2 on page 159.

The legal term *for a "complaint" is a* ***"grievance."***

The legal term *for "making a complaint" is* ***"filing a grievance."***

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950).

Section 10.1: Internal complaints

To make an internal complaint, call Customer Care at the number at the bottom of the page. There you can also use the physician finder and get health news and information. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- If there is anything else you need to do, Customer Care will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- You can send your complaint to us in writing at:
  Humana Inc.
  Attn: Grievances and Appeals
  PO Box 14546
  Lexington, KY 40512-4546.

You will need to include who/what the complaint is about (see above for some examples of what you can complain about) and any information supporting the complaint (date of incident, reference numbers, claim numbers, etc.). Humana will review the complaint and request any additional information. Humana will notify you of the outcome of the complaint within 30 days of the receipt of the complaint.

The legal term *for "fast complaint" is* ***"expedited grievance."***

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Office of Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Toll Free: 1-800-368-1019
TDD 1-800-537-7697

You may also have rights under the Americans with Disability Act and under Virginia Human Rights Act. You can contact the Commonwealth Coordinated Care Ombudsman at 1-800-552-5019 (TTY: 1-800-464-9950).

You can file a complaint with the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).

- Or you can make your complaint to us ***and*** *also* to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

In Virginia, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-844-455-8708 (TTY: 1-855-843-4776).

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

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Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medicaid benefits if you leave our plan.

A. When can you end your membership in our Medicare-Medicaid plan?

You can end your membership in Humana Gold Plus Integrated (Medicare-Medicaid Plan) at any time with no penalty. Your membership will end on the last day of the month that you ask to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month.

- For information on Medicare options when you leave our plan, see the table on page 163.
- For information about your Medicaid services when you leave our plan, see page 165.

These are ways you can get more information about when you can end your membership:

- Call state enrollment broker at 1-855-889-5243, Monday - Friday 8:30 a.m. - 6 p.m. TTY users should call 1-800-817-6608.
- Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

B. How do you end your membership in our plan?

If you decide to end your membership, tell Medicaid or Medicare that you want to leave Humana Gold Plus Integrated:

- Call state enrollment broker at 1-855-889-5243, Monday - Friday 8:30 a.m. - 6 p.m. TTY users should call 1-800-817-6608; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 164.

C. How do you join a different Medicare-Medicaid plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid plan.

To enroll in a different Medicare-Medicaid plan:

- Call state enrollment broker at 1-855-889-5243, Monday - Friday 8:30 a.m. - 6 p.m. TTY users should call 1-800-817-6608. Tell them you want to leave Humana Gold Plus Integrated and join a different Medicare-Medicaid plan. If you are not sure what plan you want to join, they can tell you about other plans in your area; OR

Your coverage with Humana Gold Plus Integrated will end on the last day of the month that we get your request.

D. If you leave our plan and you do not want a different Medicare-Medicaid plan, how do you get Medicare and Medicaid services?

If you do not want to enroll in a different Medicare-Medicaid plan after you leave Humana Gold Plus Integrated, you will go back to getting your Medicare and Medicaid services separately.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your new Medicare Advantage plan's coverage begins. You will get your Medicaid benefits separately through fee-for-service.
2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your Original Medicare coverage begins. You will get your Medicaid benefits separately through fee-for-service.
3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Virginia Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402. You will automatically be disenrolled from Humana Gold Plus Integrated when your Original Medicare coverage begins. You will get your Medicaid benefits separately through fee-for-service.

How you will get Medicaid services

If you do not want to enroll in a different Medicare-Medicaid plan after you leave Humana Gold Plus Integrated, you will go back to getting your Medicaid services through the fee for service program with Medicaid.

Your Medicaid services include most long-term services and supports and behavioral health care. These include Elderly or Disabled with Consumer Direction Waiver services and Community Mental Health Rehabilitation services. See Chapter 4 for more details about these services.

If you leave the Medicare-Medicaid plan, you can see any provider that accepts Medicaid.

E. Until your membership ends, you will keep getting your medical services and drugs through our plan

If you leave Humana Gold Plus Integrated, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. See page 163, Section D, for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled**. Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged**. This will happen even if your new health coverage begins before you are discharged.

F. Your membership will end in certain situations

These are the cases when Humana Gold Plus Integrated must end your membership in the plan:

- If there is a break in your Medicare Part A and/or Part B coverage.
- If you no longer qualify for full-benefit Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you have other comprehensive health insurance.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Care at the number at the bottom of the page to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.

If you have questions, please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com**.

You must be a United States citizen or lawfully present in the United States to be a member of our plan. The Centers for Medicare and Medicaid Services will notify us if you aren't eligible to remain a member on this basis. We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. We *cannot* ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week. You should also call the Medicaid helpline at 804-786-6145.

The only exception is if you decide to enroll in a hospice program. If you enroll in hospice, we must disenroll you from our plan so you can receive those services. You can then see any Medicaid or Medicare provider.

H. You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also see Chapter 9, Section 10, page 157 for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when we can end your membership, you can call Customer Care the number at the bottom of the page.

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your age, claims experience, color, creed, ethnicity, evidence of insurability, gender, genetic information, geographic location, health status, medical history, mental or physical disability, national origin, race, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 12: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9, Section 5.3, page 129 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost-sharing amount for services. As a member of Humana Gold Plus Integrated, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. Call Customer Care if you get any bills that you do not understand.

Benefits: A schedule of health care services to be delivered to you covered by the Health Plan.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care manager: One main person from our health plan who works with you and with your care providers to make sure you get the care you need.

Care plan: A plan for what health services you will get and how you will get them.

Care Team: A Care Team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $4,850 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 21 explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Consumer-directed (CD) model of services: means the model of service delivery for which the waiver Enrollee or the Enrollee's employer of record, as appropriate, are responsible for hiring, training, supervising, and firing of the person or persons who actually render the services.

Contract(s): The Contract between U.S. DHHS Centers for Medicare & Medicaid Services in Partnership with the State of Virginia and Humana Gold Plus Integrated for the Demonstration.

Copay: A fixed amount you pay as your share of the cost each time you get a service or supply. For example, you might pay $2 or $5 for a service or a prescription drug.

Cost-sharing: Amounts you have to pay when you get services or drugs. Cost-sharing includes copays and coinsurance.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, Section 4, page 124 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Customer Care: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, Section A, page 14 for information about how to contact Customer Care.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply. Here is an example: If your copay for a one-month supply of a drug is $1.20, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $0.04 per day. This means you pay $0.04 for each day's supply when you fill your prescription.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Elderly or Disabled with Consumer Direction (EDCD) Waiver: The CMS-approved §1915(c) waiver that covers a range of community support services offered to Enrollees who are elderly or who have a disability who would otherwise require a nursing facility (NF) level of care.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain. Medical emergency is further defined in Chapter 3, Section I, page 33

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services: Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Enrollee: See "Member" below

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home and Community-Based Services (HCBS) Waiver: A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to get one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (NF) placement.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. Humana Gold Plus Integrated must give you a list of hospice providers in your geographic area.

Initial coverage stage: The stage before your total Part D drug expenses reach $4,850. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Licensed: A facility, equipment or an individual that has formally met State, county and local requirements, and has been granted a License by a local, State or federal government entity.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): See "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section H, page 22 for information about how to contact Medicaid in your state.

Medical Record: Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

Medically necessary: This describes services to prevent, diagnose, or treat your medical condition or to maintain your current health status, or an item or service provided for the diagnosis or treatment of your condition consistent with standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Humana Gold Plus Integrated includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Model of care: Provides structure for care management processes and systems that will enable care managers to provide coordinated care.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman's services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9, Section 4, page 124 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out of network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D, page 28 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. See the definition for "cost-sharing" above.

Outpatient: A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to get, and who does get, professional services for less than a twenty-four (24) hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Patient Pay: The amount you may have to pay for long-term care services based on your income. The Virginia Department of Social Services must calculate your patient pay amount if you live in a nursing facility or get EDCD Waiver services. However, you may not have to pay the amount every month.

Preauthorization: The act of authorizing specific services before they are rendered.

Primary Care: Comprehensive, coordinated and readily accessible medical care including: health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section D, page 28 for information about getting care from primary care providers.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, Section D, page 42 Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider: A person or entity that meets all State and/or federal requirements (as appropriate) to provide Covered Services to Demonstration Members.

Quality: The degree to which a Health Plan increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, Section F, page 20 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can get each time you fill your prescription.

Referral: In most cases, your network PCP must give you approval before you can use other providers in the plan's network. This is called a referral. See Chapter 3, Section D, page 28 through 32, to learn more about referrals.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. See Chapter 4, Section D, page 42 to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State: Commonwealth of Virginia.

State Medicaid agency: The Commonwealth of Virginia Department of Medical Assistance Services (DMAS)

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Transportation: An appropriate means of conveyance furnished to you to obtain Demonstration authorized/ Covered Services.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Virginia Department of Health: The State agency which oversees public health throughout the Commonwealth of Virginia.

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 auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-855-280-4002, or if you use a TTY, call 711.

If you believe that **Humana Inc.** and 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

If you need help filing a grievance, call 1-855-280-4002 or if you use a TTY, call 711.

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 **1-855-280-4002 (TTY: 711).**

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-280-4002 (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 **1-855-280-4002 (TTY: 711)**。

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-855-280-4002 (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 **1-855-280-4002 (TTY: 711).**

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-280-4002 (телетайп: 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 **1-855-280-4002 (TTY: 711).**

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-855-280-4002 (ATS : 711).**

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-855-280-4002 (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 **1-855-280-4002 (TTY: 711).**

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-855-280-4002** (رقم هاتف الصم والبكم: **711**).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-280-4002 (TTY: 711)** पर कॉल करें।

اُردُو (Urdu):
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-855-280-4002 (TTY: 711)** ۔

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-855-280-4002 (TTY: 711)** تماس بگیرید.

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-855-280-4002 (መስማት ለተሳናቸው: 711)**.

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-855-280-4002 (TTY: 711)**।

Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa): Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ ìn m̀ gbo kpáa. Đá **1-855-280-4002 (TTY: 711)**

? **If you have questions,** please call Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan at 1-855-280-4002, (TTY: 711), Monday - Friday, from 8 a.m. - 8 p.m. Eastern time. The call is free. **For more information,** visit **Humana.com.**

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call **1-855-280-4002 (TTY: 711)**.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-855-280-4002 (TTY: 711)**.