

2021

Member Handbook

Humana Gold Plus Integrated
(Medicare-Medicaid Plan)

Illinois

Humana®

Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member Handbook

January 1, 2021–December 31, 2021

Your Health and Drug Coverage under the Humana Gold Plus Integrated (Medicare-Medicaid Plan)

Member Handbook Introduction

This handbook tells you about your coverage for the time you are enrolled with Humana Gold Plus Integrated (Medicare-Medicaid Plan) through December 31, 2021. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports include long-term care and home and community based waivers (HCBS). HCBS waivers can offer services that will help you stay in your home and community. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

This Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 (Medicare-Medicaid Plan).

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [1-800-787-3311] (TTY: 711). Estamos disponibles de lunes a viernes, de 8 a.m. a 8 p.m. hora Central. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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.

- Call Customer Care if you want to make or change a standing request at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
- We will keep your preferred language other than English and/or alternate format for future mailings and communications.
- You will not need to make a separate request each time.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Disclaimers

Humana Gold Plus Integrated H0336-001 (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

Coverage under Humana Gold Plus Integrated (Medicare-Medicaid Plan) is qualifying health coverage called "minimum essential coverage". 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/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Limitations, copays, and restrictions may apply. For more information, call Humana Gold Plus Integrated (Medicare-Medicaid Plan) Customer Care or read this Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 (Medicare-Medicaid Plan) 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.

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Chapter 1: Getting started as a member

Introduction

This chapter includes information about Humana Gold Plus Integrated (Medicare-Medicaid Plan), a health plan that covers all your Medicare and Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from Humana Gold Plus Integrated (Medicare-Medicaid Plan). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

A. Welcome to Humana Gold Plus Integrated (Medicare-Medicaid Plan)

Humana Gold Plus Integrated (Medicare-Medicaid Plan) is a Medicare-Medicaid Plan. 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 coordinators 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 (Medicare-Medicaid Plan) was approved by the State of Illinois and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Medicare-Medicaid Alignment Initiative.

The Medicare-Medicaid Alignment Initiative is a demonstration program jointly run by Illinois 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. Information about Medicare and Medicaid

B1. 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).

B2. 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.

Each state decides:

- what counts as income and resources,
- who qualifies,
- 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 Illinois must approve Humana Gold Plus Integrated (Medicare-Medicaid Plan) each year. You can get Medicare and Medicaid services through our plan as long as:



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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

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

C. Advantages of this plan

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

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

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- 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 coordinator. This is a person who works with you, with Humana Gold Plus Integrated (Medicare-Medicaid Plan), 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 coordinator.
- The care team and care coordinator 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. Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s service area

Our service area includes these counties in IL: All counties statewide

Only people who live in our service area can get Humana Gold Plus Integrated (Medicare-Medicaid Plan).

If you move outside of our service area, you cannot stay in this plan. See Chapter 8 for more information about the effects of moving out of our service area.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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 have both Medicare Part A and Medicare Part B, **and**
- you are eligible for Medicaid, **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are age 21 and older at the time of enrollment, **and**
- you are enrolled in the Medicaid Aid to the Aged, Blind and Disabled category of assistance, **and**
- if you meet all other Demonstration criteria and are in one of the following Medicaid 1915(c) waivers:
 - Persons who are Elderly;
 - Persons with Disabilities;
 - Persons with HIV/AIDS;
 - Persons with Brain Injury; or
 - Persons residing in Supportive Living Facilities.

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 90 days.

The health risk assessment helps us understand your medical needs. We will attempt to reach you by phone to complete the assessment. If we can't reach you by phone, then we will mail you the form to complete. We will send you a postage paid return envelope to send it back. If you need help completing the form, we can call you or meet face-to-face. If you need help, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

If this is your first time in a Medicare-Medicaid Plan, you can keep seeing the doctors you go to now for 180 days. **If you changed to Humana Gold Plus Integrated (Medicare-Medicaid Plan) from a different Medicare-Medicaid Plan**, you can keep seeing the doctors you go to now for 90 days. During the transition time, your care coordinator will contact you to help you find providers in our network.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

After 180 days, you will need to see doctors and other providers in the Humana Gold Plus Integrated (Medicare-Medicaid Plan) network. A network provider is a provider who works with the health plan. See Chapter 3, Section B, page 28 for more information on getting care.

G. Your care plan

Your care plan is the plan for what medical, behavioral, long term supports, social and functional 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 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 if the services you need and want change.

If you are getting Home and Community-based Waiver services, you will also have a service plan. The service plan lists the services you will get and how often you will get them. This service plan will become part of your overall care plan.

H. Humana Gold Plus Integrated (Medicare-Medicaid Plan) monthly plan premium

Humana Gold Plus Integrated (Medicare-Medicaid Plan) does not have a monthly plan premium.

I. 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 D, page 125 or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Customer Care at 1-800-787-3311 (TTY: 711) Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. You can also see the *Member Handbook* at **Humana.com** or download it from this website.

The contract is in effect for the months you are enrolled in Humana Gold Plus Integrated (Medicare-Medicaid Plan) between January 1, 2021 and December 31, 2021.

J. Other information you will get from us

You should have already gotten a Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

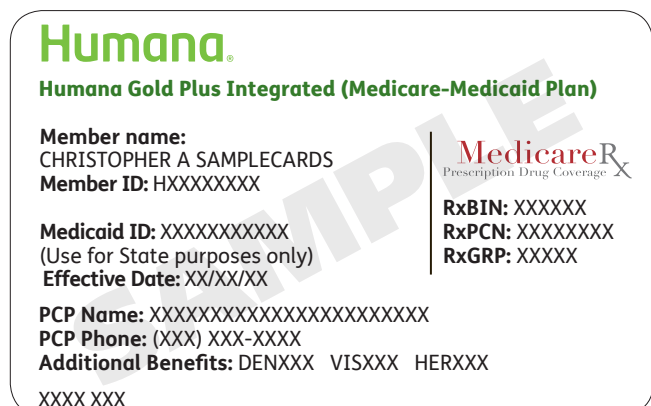
J1. Your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card

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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

sample card to show you what yours will look like:



If your card is damaged, lost, or stolen, call Customer Care at 1-800-787-3311 (TTY: 711) Monday – Friday, from 8 a.m. – 8 p.m. Central time right away and we will send you a new card. The call is free.

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. If you show your Medicare card instead of your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. See Chapter 7 to see what to do if you get a bill from a provider.

J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 30).

You can ask for a *Provider and Pharmacy Directory* by calling Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. You can also see the *Provider and Pharmacy Directory* on our website at **Humana.com**. You can also download it from this website. Both Customer Care and the website can give you the most up-to-date information about changes in our network providers.

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

Definition of network providers

- Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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.

Definition of 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 1-800-787-3311 (TTY: 711) for more information or to get a copy of the *Provider and Pharmacy Directory*. We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. This call is free. You can also see the *Provider and Pharmacy Directory* at **Humana.com** or download it from this website. Both Customer Care and Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells which prescription drugs are covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan).

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, page 92 for more information on these rules and restrictions.

Each year, we will send you information about how to access 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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

J4. 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 *EOB* 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. The *EOB* gives more information about the drugs you take and how it can help you keep track of your drug coverage.

An *EOB* is also available when you ask for one. To get a copy, contact Customer Care.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

K. How can you keep your enrollee profile up to date?

You can keep your enrollee profile 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 enrollee profile 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:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- Any liability claims, such as claims from an automobile accident
- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study

If any information changes, please let us know by calling Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

K1. Privacy of personal health information (PHI)

The information in your enrollee profile may include personal health information (PHI). Laws require that we keep your medical records and PHI. We make sure that your health information is protected. For more information about how we protect your PHI, see Chapter 8, Section D, page 114.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Humana Gold Plus Integrated (Medicare-Medicaid Plan) and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

A. How to contact Humana Gold Plus Integrated (Medicare-Medicaid Plan) Customer Care

CALL	<p>1-800-787-3311 This call is free.</p> <p>We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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 such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Hours of operation are the same as above.</p>
WRITE	Humana PO Box 14168 Lexington, KY 40512-4168
WEBSITE	Humana.com

A1. When to contact Customer Care

- Questions about the plan
- Questions about claims, billing or Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 D, page 125.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- 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 D, page 125.
- 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*, page 20).
 - 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 (Medicare-Medicaid Plan) right to Medicare. You can use an online form at 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 J, page 158.
- 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 F4, page 141.
- 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 1-800-787-3311 (TTY: 711) Monday – Friday, from 8 a.m.– 8 p.m. Central time or by writing to us using the address below:

Humana Inc.
Grievance and Appeal
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 F5, 144.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- Complaints about your drugs
 - You can make a complaint about us or a 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, page 13*).
 - You can send a complaint about Humana Gold Plus Integrated (Medicare-Medicaid Plan) right to Medicare. You can use an online form at 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 J, page 158.
- 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 107.
 - 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 D, page 125 for more on appeals.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B. How to contact your care coordinator

With your Humana Gold Plus Integrated (Medicare-Medicaid 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 coordinator by telephone. In-person home visits may also be available if you have complex health, mental health or long term service needs.

Your care coordinator will work with you and any family members or other caregivers you choose. Your care coordinator 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 coordinator may also involve other health professionals like nurses, social workers, long term service and behavioral health specialists – this is your care team.

Our care coordinators are here to help keep you safe and healthy. For example, your care coordinator 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 all 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
- Provide care support after a hospitalization
- Help you return to the community after a nursing home or inpatient stay
- Develop a crisis plan to help keep you safe in times of emergency
- Make your home safer for you to stay in



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

See the chart below to contact your care coordinator. If you do not yet have one, ask for one by using the same chart.

CALL	<p>1-800-787-3311 This call is free.</p> <p>We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit Humana.com for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Hours of operation are the same as above.</p>
WRITE	Humana PO Box 14168 Lexington, KY 40512-4168
WEBSITE	Humana.com

B1. When to contact your care coordinator

- Questions about your health care
- Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)
- If your provider or Care Coordinator thinks you may be eligible for long-term care or additional supports and services to keep you in your home, they will refer you to an agency that will decide if you are eligible for those services.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Sometimes you can get help with your daily health care and living needs. If you qualify for LTSS, you might be able to get these services:

- Adult Day Service - Also known as Adult Day Care
- Behavioral Services
- Day Habilitation – Also known as Habilitation
- Emergency Home Response System
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Home Health Care
- Homemaker
- Nursing - Intermittent
- Nursing - Skilled
- Personal Assistant
- Personal Emergency Response System
- Physical, Occupational and Speech Therapy – also known as Rehabilitation Services
- Prevocational Services
- Respite
- Skilled nursing care
- Specialized Equipment and Supplies, and
- Supportive Living Program – Also known as Supportive Living Service



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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	1-855-235-8530 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. Hours of operation are the same as above.

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

D. How to contact the Behavioral Health Crisis Line

CALL	1-855-371-9234 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. Hours of operation are the same as above.

D1. When to contact the Behavioral Health Crisis Line

- If you have a life threatening emergency or an emergency that poses a threat to the lives of others or property, call 911 or go directly to the nearest emergency room.
- If you have a mental health crisis, you can get help by calling the Crisis Hotline. Qualified mental health professionals will be available 24 hours per day, 7 days per week to answer your questions, assess your mental health, and provide and coordinate services as needed.
- Questions about behavioral health services.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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

The Senior Health Insurance Program (SHIP) gives free health insurance counseling to people with Medicare. SHIP is not connected with any insurance company or health plan.

CALL	1-800-252-8966 Monday – Friday 8:30 a.m. – 5 p.m. The call is free.
TTY	1-888-206-1327 Monday – Friday 8:30 a.m. – 5 p.m. The call is free.
WRITE	Senior Health Insurance Program Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271
EMAIL	AGING.SHIP@illinois.gov
WEBSITE	www2.illinois.gov/aging/ship/Pages/default.aspx

E1. When to contact the SHIP

- Questions about your Medicare health insurance
 - SHIP counselors can answer your questions about changing to a new plan and help you:
 - understand your rights,
 - understand your plan choices,
 - answer your questions about changing to a new plan,
 - make complaints about your health care or treatment, **and**
 - straighten out problems with your bills.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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

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

CALL	Toll-free Phone 1-888-524-9900 Toll-free TTY 1-888-985-8775
WRITE	Livanta 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

F1. When to contact Livanta

- 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,
 - think your hospital stay is ending too soon, **or**
 - 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

WEBSITE	<p>www.medicare.gov</p> <p>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.”</p> <p>The Medicare website has the following tool to help you find plans in your area:</p> <p>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 plans.”</p> <p>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.</p>
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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, call the Illinois Department of Human Services Customer help line.

CALL	1-800-843-6154 Monday – Friday 8 a.m. – 5 p.m. The call is free.
TTY	1-866-324-5553 Monday – Friday 8 a.m. – 5 p.m. The call is free.
EMAIL	DHS.WebBits@illinois.gov
WEBSITE	www.dhs.state.il.us



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

I. How to contact the Illinois Health Benefits Hotline

The Illinois Department of Healthcare and Family Services Health Benefits Hotline provides general information about Medicaid benefits.

CALL	1-800-226-0768 Monday – Friday 8 a.m. – 4:30 p.m. The call is free.
TTY	1-877-204-1012 Monday – Friday 8 a.m. – 4:30 p.m. The call is free.
WEBSITE	www.hfs.illinois.gov This is the official website for Medicaid. It gives you up-to-date information about Medicaid.

J. How to contact the Illinois Home Care Ombudsman Program

The Illinois Home Care Ombudsman Program is an ombudsman program that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. They also can help you file a complaint or an appeal with our plan. The Illinois Home Care Ombudsman is not connected with any insurance company or health plan. Their services are free.

CALL	1-800-252-8966 Monday – Friday 8:30 a.m. – 5 p.m. The call is free.
TTY	1-888-206-1327 Monday – Friday 8:30 a.m. – 5 p.m. The call is free.
WRITE	Home Care Ombudsman Program Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271
EMAIL	Aging.HCOProgram@illinois.gov
WEBSITE	www.illinois.gov/aging/programs/LTCOmbudsman/Pages/The-Home-Care-Ombudsman-Program.aspx



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

K. Other resources

Care Coordination Units (CCUs) serve as central access points for older adults who have intensive long term care needs. If an older adult has a functional impairment(s) and needs housekeeping assistance, home-delivered meals, personal care, or other services, he or she could contact the nearest CCU. It may be located in a senior center or other social service agency. A care coordinator assesses the person's needs, determines eligibility for various programs, develops a plan of care and arranges for services.

CALL	1-312-744-4016 (TTY: 1-312-744-6777) (City of Chicago)
WRITE	Senior Services Area Agency on Aging Chicago Department of Family and Support Services 1615 W. Chicago Avenue, 3rd Floor Chicago, IL 60622
EMAIL	aging@cityofchicago.org
WEBSITE	www.cityofchicago.org

CALL	1-800-699-9043 (Suburban Cook County area only)
WRITE	AgeOptions, Inc. 1048 Lake Street, Suite 300 Oak Park, Illinois 60301
EMAIL	information@ageoptions.org
WEBSITE	www.ageoptions.org

CALL	1-800-528-2000 (DuPage, Kane, Kankakee, Lake, and Will Counties) Hours of Operation 8:00 am – 4:30 PM – Central Time, Monday – Friday. The call is free.
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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

WRITE	Northeastern Illinois Area Agency on Aging P.O. Box 809 Kankakee, IL 60901
EMAIL	info@ageguide.org
WEBSITE	www.state.il.us/aging/

Consumer Advisory Committee

As a member of our health plan, you may be invited to meet with your peers as part of a Consumer Advisory Committee. During our committee, you will tell us how we can better serve you. Members are randomly invited to join. If invited you will be mailed an invitation. Joining will allow you, your caregiver, or family member the chance to attend a community gathering. The gatherings will take place once every three months for two hours. Complimentary refreshments will be provided at each gathering. Transportation to and from the meeting is available if needed. If chosen, and cannot attend in person, you may call into the meeting. The phone number will be provided in the mailed invitations. Your concerns will be heard. We really look forward to seeing our members!

CALL	1-877-291-6608 and press “2”
WRITE	550 West Adams Street Attention: Market Quality Operations Chicago, IL 60661
EMAIL	Greatlakesquality@humana.com
WEBSITE	www.humana.com/medicare/medicaid-dual/illinois/

Adult Protective Services (APS)

Adult Protective Services (APS) serves as an access point for reporting abuse, neglect, or financial exploitation of a person age 60 or older or adults with disabilities age 18-59. Abuse, neglect and exploitation come in a variety of forms. Examples include physical abuse (causing pain or injury), sexual abuse (sexual activity with a person that is unable or unwilling to consent) and financial exploitation (misuse or theft of a person's resources). Warning signs may include unexplained injuries, missing property or funds, or a person that appears unclean or is living in an unclean environment despite having a caregiver. Any reports to APS of abuse, neglect or exploitation are investigated by an APS case worker. If you, or someone you know, is experiencing abuse, neglect or exploitation please contact APS. If needed, your Humana Care Coordinator can assist you with contacting APS.

CALL	1-866-800-1409, 1-888-206-1327 (TTY)
WEBSITE	www2.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit Humana.com.

Quality Improvement (QI) Program

We have a Quality Improvement (QI) program that focuses on clinical and preventive care and member service functions of the health plan. You have a right to tell us about changes you think we should make. To tell us about changes or get a printed copy of the Humana Quality Improvement (QI) program, mail a request to the following address: Humana Quality Operations Compliance and Accreditation Department, QI Progress Report, 321 West Main Street, WFP 20, Louisville, KY 40202 or call Humana Gold Plus Integrated (Medicare-Medicaid Plan) Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Humana Gold Plus Integrated (Medicare-Medicaid Plan). It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

A. Information 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 C, page 44.

Providers are doctors, nurses, specialists 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 (LTSS) covered by the plan

Humana Gold Plus Integrated (Medicare-Medicaid Plan) covers all services covered by Medicare and Medicaid. This includes medical, behavioral health, and long-term services and supports.

Humana Gold Plus Integrated (Medicare-Medicaid Plan) will generally pay for the health care and services you get if you follow the plan rules. To be covered by our plan:

- 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 C, page 44 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. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.
- 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 see someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Humana Gold Plus Integrated (Medicare-Medicaid Plan) may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. To learn more about referrals, see page 33.
 - You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 33.
 - To learn more about choosing a PCP, see page 31.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- **NOTE:** If this is your first time in a Medicare-Medicaid Plan, you may continue to see your current providers for the first 180 days with our plan, at no cost, if they are not a part of our network. If you changed to Humana Gold Plus Integrated (Medicare-Medicaid Plan) from a different Medicare-Medicaid Plan, you may continue to see your current providers for the first 90 days with our plan, at no cost, if they are not a part of our network. During the transition time, our care coordinator will contact you to help you find providers in our network. After that time, we will no longer cover your care if you continue to see out-of-network providers.
- **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 Section I, page 38.
 - 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. 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 Section D, page 35.
 - 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 the providers you see now for 180 days. If you changed to Humana Gold Plus Integrated (Medicare-Medicaid Plan) from a different Medicare-Medicaid Plan, you can keep seeing the doctors you go to now for 90 days. Your care will continue through this period or until you choose another PCP. If the provider's quality of care is in question, this may not be possible. If you are receiving services as part of a Williams or Colbert consent decree, we will work also to ensure continuity of care by honoring the service plan that is in place for you.

C. Information about your care coordinator

C1. What a care coordinator is

With your Humana Gold Plus Integrated (Medicare-Medicaid Plan), you have a whole care team to work with to help support meeting your health needs and goals. This service is part of your 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 coordinator by telephone. Your care coordinator 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 coordinator will work with you and any family members or other caregivers you choose.

Your care coordinator 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 coordinator 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 (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

Our care coordinators are here to help keep you safe and healthy. For example, your care coordinator 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 all 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
- Provide care support after a hospitalization
- Help you return to the community after a nursing home or inpatient stay
- Develop a crisis plan to help keep you safe in times of emergency
- Make your home safer for you to stay in

C2. How you can contact your care coordinator

To contact your care coordinator call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. This call is free.

C3. How you can change your care coordinator

If you want to change your care coordinator, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. This call is free.

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

D1. Care from a primary care provider

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

Definition of “PCP,” and what a PCP does 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.

Sometimes new treatments work very well and sometimes they do not. Some can even have bad side effects. Humana Gold Plus Integrated tracks new medical research. This is how it decides new benefits for your health plan. If you think a new medical technology or treatment might help you, call your PCP. Your PCP will work with Humana Gold Plus Integrated to see if it can help you and if it will be covered by Humana Gold Plus Integrated.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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. Your PCP will also help obtain prior authorization from us when needed.

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 doctor
- General practitioner
- Internist
- Federally Qualified Health Center or a Rural Health Center
- Women's Health Care Provider (WHCP) or OB/GYN

A Women's Health Care Provider (WHCP) is a doctor, nurse practitioner or other provider who specializes in obstetrics, gynecology, or family practice. Female members may choose a WHCP as their PCP or may see a WHCP as needed and without a referral.

Members who are identified as American Indian/Alaskan Native may see providers who are designated as Indian Health Care Providers if they choose to. They are not limited to these providers and can choose any network provider. For help in locating an Indian Health Care Provider, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

In some cases, a specialist may be a PCP, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

Your choice of PCP

For information on choosing your PCP, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

If you would prefer to have a PCP that has the same cultural, ethnic or racial background as you, please call Customer Care at the number above.

Option to change your PCP

You may change your PCP for any reason, at any time during the year. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the new one you have now leaves our network.

If you want to change your PCP for any reason, you must call Customer Care to let us know. Change requests received 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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

If you need a copy of the *Provider and Pharmacy Directory*, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

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

If your PCP tells us that he or she is moving away, retiring or leaving our network for any reason, we will assign another PCP for you. We will let you know by mail within 45 days whenever possible. You can call us if you need help choosing a different PCP. We will also let you know if any hospitals in your region stop



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accepting Humana Gold Plus Integrated (Medicare-Medicaid Plan).

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.

D2. 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 or Women's Health Care Provider (WHCP) can recommend a specialist to you if you have a specific



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For more information, visit **Humana.com**.

problem. Your PCP or WHCP 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 (Medicare-Medicaid Plan) 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 44 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 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 "Option to change 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.

D3. What to do when a network provider leaves our plan

A network provider you are using might leave our plan.

- If a network provider you are using leaves our plan, we will give you at least 30 days' notice so that you have time to select a new provider.
- If your provider leaves the plan's network, we will allow a transition period of 90 days from date of notice if you have an ongoing course of treatment or are in your third trimester of pregnancy, including postpartum care.

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.
- We will make a good faith effort to give you at least 60 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 that the medically necessary treatment you are getting is not interrupted. We will work with you to ensure you continue getting the treatment you need.
- 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. Call 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

8 a.m. – 8 p.m. Central time. The call is free.

D4. 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 for more information about which services require prior authorization.

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.
- A provider must be enrolled as an Illinois Medicaid Provider to get paid for any Medicaid services they provide to you.

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

As a Humana Gold Plus Integrated (Medicare-Medicaid Plan) member, you may receive services in a nursing facility or you may qualify for a Medicaid Home and Community-Based Services (HCBS) Waiver.

Long-term services and supports are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home.

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 (Medicare-Medicaid Plan) care coordinator.

If you have questions, you can call us at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

F. How to get behavioral health services

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

For behavioral health services, please call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

finder and get health news and information.

G. How to get self-directed care

Depending on your LTSS Waiver eligibility, you may be able to select the Personal Assistant (PA) service. This service allows you to choose who will provide personal care services to you. If you qualify, your care coordinator can assist you with signing up for self-directed care.

If you employ a PA, it is your responsibility to ensure the following:

- You need to complete and submit all necessary documentation to the local Home Services Program (HSP) office prior to the start of employment of the PA. This includes information in both the Member and PA packets.
- You need to select a PA that has the physical capability to perform the tasks under your direction, and the PA will not have a medical condition which will be aggravated by the job requirements.
- You need to provide a copy of and review your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Service Plan with your PA so they understand your needs and hours approved.
- You will review the Time Sheet with your PA for accuracy of all information before you turn it in, and only approve hours actually worked by the PA for payment.
- Time Sheets will not be pre-signed or submitted prior to the last day worked in a billing period.
- Complete the PA's Last Day of Employment form (in your packet) and send to the HSP office when any PA's employment ends.
- Notify the HSP office within 24 hours of any incident resulting in injury to the PA at work.
- Complete the Report of Injury to a Provider form (in your packet) and mail or fax it to the HSP office within 24 hours after you reported it.

G1. What self-directed care is

Self-directed care allows you and/or your family the right to create a care plan that matches your wishes. Your care coordinator can assist you.

G2. Who can get self-directed care

Your care coordinator can tell you if you can get self-directed care.

G3. How to get help in employing personal care providers

Your care coordinator can tell you how to employ a personal care provider.

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 1-855-253-6867.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

(TTY: 711) Monday – Friday 8 a.m. – 8 p.m. Central time. This call is free.

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

II. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **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, when:
 - there is not enough time to safely transfer you to another hospital before delivery.
 - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to 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 Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

Covered services in a medical emergency

Medicare and Medicaid do not provide coverage for emergency medical care outside the United States and its territories.

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 C, page 44.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell



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For more information, visit **Humana.com**.

us when your medical emergency is over.

Post Stabilization Care is care you get after you have received emergency medical services. It helps maintain, improve or clear up your health issue. It does not matter whether you get the emergency care in or outside of our network. These services may be provided in the hospital or in an office setting. We will cover services to make sure you are stable after an emergency. You should get care until your condition is stable.

What to do if you have a behavioral health emergency

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health 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.)

I2. Urgently needed care

Definition of 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.

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 1-800-622-9529 (TTY: 711) 24 hours a day, 7 days a week.

OR



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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.

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 care that you get outside the United States.

I3. 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 (Medicare-Medicaid Plan).

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 no cost to you. 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 to do if you are billed directly for 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 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 for your covered services, or if you have gotten a bill for covered medical services, see Chapter 7, Section A, page 107 to learn what to do.

J1. What to do if services are not covered by our plan

Humana Gold Plus Integrated (Medicare-Medicaid Plan) covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (see Chapter 4, Section C, page 44), **and**
- that you get by following plan rules.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section E, page 128 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. Coverage of health care services covered when you are in a clinical research study?

K1. Definition of 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 or our plan 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. If you plan to be in a clinical research study, you or your care coordinator should contact Customer Care to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- 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.

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.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 your health care services are covered when you get care in a religious non-medical health care institution

L1. Definition of 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.

L2. Getting care from a religious non-medical health care institution

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 C, page 47 (Medical Benefits Chart) for more information.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME means certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Humana Gold Plus Integrated (Medicare-Medicaid Plan), 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.

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

NOTE: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2021 Handbook*. If you don't have a copy of this booklet, you can get it at the Medicare website (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.

You will have to make 13 payments in a row under Original Medicare or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan **and**
- you leave our plan and get your Medicare benefits through Original Medicare instead of a health plan.

If you made payments for the DME under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the 13 payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit [Humana.com](https://www.humana.com).

- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment
- Oxygen equipment must be returned to the owner when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and you leave our plan and switch to Original Medicare, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above. If oxygen equipment is medically necessary after you rent it for 36 months:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary at the end of the 5-year period:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and you leave our plan and switch to a Medicare Advantage plan, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.”

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Humana Gold Plus Integrated (Medicare-Medicaid Plan) covers and any restrictions or limits on those services . It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

A. Your covered services

This chapter tells you what services Humana Gold Plus Integrated (Medicare-Medicaid Plan) covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section B, page 92. 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 28 for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

B. Rules against providers charging you for services

We do not allow Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 107 or call Customer Care.

C. Our plan's Benefits Chart

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections, General Services offered to all enrollees, and Home and Community-based Services offered to enrollees who qualify through a home and community-based services waiver program.

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 services 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 services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.
- 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 30 has more information about using network and out-of-network providers.



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- 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 someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3, Section D, page 30 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 prior authorization are marked in the Benefits Chart by an asterisk (*). In addition, you must get prior authorization for the following services that are not listed in the Benefits Chart:

Diagnostic and Cardiac testing

Breast cancer biopsy (excisional)
Capsule Endoscopy
Cardiac catheterization
Computed Tomography
EGD
Electrophysiology (EPS) with or without mapping
Loop recorder
Molecular diagnostics/genetic testing
MRI/MRA Magnetic resonance imaging and angiograms
Myocardial perfusion imaging
Nuclear stress test
Outpatient transthoracic echocardiogram (TTE)
Positron emission tomography (PET scan)/national oncology PET registry (NOPR)
SPECT Single photon emission computed tomography
Transesophageal echocardiogram (TEE)

Pain Management

Epidural steroid injections
Facet injections
Pain pump implants
Spinal cord stimulators
Spinal surgeries – spinal fusion, decompression, kyphoplasty and vertebroplasty

Surgeries/procedures

Abdominoplasty
Ablation – Cardiac, bone, liver, kidney and prostate
Arthroscopy – hip, knee and shoulder
Blepharoplasty
Breast Procedures (Excludes breast reconstruction following medically necessary mastectomies for breast cancer)
Decompression of peripheral nerve (carpal tunnel)
Foot surgeries – bunionectomy and hammer toe
Lung biopsy and resection
Outpatient coronary angioplasty/stent
Obesity Surgeries
Oral, Orthognathic, Otoplasty



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Penile Implant
Peripheral revascularization (arthrectomy/angioplasty)
Surgery for Obstructive Sleep apnea
Surgical Nasal/Sinus Endoscopic Procedures and Balloon sinus ostial dilation endoscopies
Temporomandibular Joint (TMJ) Surgeries
Transcatheter Valve surgeries (TMVR/TAVR, TAVI and MitraClip)
Thyroid surgeries
Transplant Surgeries
Varicose Vein: Surgical Treatment and Sclerotherapy

Other services


Bone growth stimulators
Chemotherapy agents and supportive drugs and symptom management drugs
Chimeric antigen receptor-T cell therapy (Car-T)
Cochlear and auditory brainstem implants
Wearable cardiac devices
Transcranial magnetic stimulation (MH/SUD service)
Gastric Pacing*
High Frequency Chest Compression Vests
Home Health/Home Infusion
Hyperbaric Therapy
Neuromuscular Stimulators
Noninvasive Home Ventilators
Orthotics/Prosthetics
Radiation therapy



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All preventive services are free. You will see this apple  next to preventive services in the Benefits Chart.

D. The Benefits Chart

Services that our plan pays for	What you must pay
 Abdominal aortic aneurysm screening The plan will cover 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
Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: <ul style="list-style-type: none"> • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; and • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse.	\$0 copay
Alcohol misuse screening and counseling The plan covers 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, the plan covers 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






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Services that our plan pays for	What you must pay
<p>Ambulance services</p> <p>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.</p> <p>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.</p> <p>In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> Annual wellness visit</p> <p>If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will cover this once every 12 months.</p> <p>Note: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.</p>	<p>\$0 copay</p>
<p> Bone mass measurement</p> <p>The plan covers 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.</p> <p>The plan will cover 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.</p>	<p>\$0 copay</p>





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Services that our plan pays for	What you must pay
 Breast cancer screening (mammograms) The plan will cover the following services: <ul style="list-style-type: none"> • 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 covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers <i>intensive</i> cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	\$0 copay *Referral may be required
 Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: <ul style="list-style-type: none"> • 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 covers 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. Additional testing may be covered if deemed medically necessary by your primary care provider.	\$0 copay




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Services that our plan pays for	What you must pay
<p>Cell Phone Services</p> <p>If you qualify for the federal free cell phone program, we offer a pre-loaded toll-free number on your phone that will allow you to call our Customer Care team. You will also get free health-related texts messages. We will help you find out if you can get access to this benefit if you need us to by calling Customer Care at the number on the bottom of the page.</p>	<p>\$0 copay</p>
<p> Cervical and vaginal cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams once every 12 months 	<p>\$0 copay</p>
<p>Chiropractic services</p> <p>The plan covers adjustments of the spine to correct alignment.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> Colorectal cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • 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 • Screening colonoscopy <p>For people at high risk of colorectal cancer, the plan will cover one screening colonoscopy (or screening barium enema) every 24 months.</p> <p>For people not at high risk of colorectal cancer, the plan will cover one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</p> <p>Additional screenings may be covered if deemed medically necessary by your primary care provider.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p> Counseling to stop smoking or tobacco use</p> <p>If you use tobacco but do not have signs or symptoms of tobacco-related disease:</p> <ul style="list-style-type: none"> The plan will cover 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. <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> The plan will cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. <p>If you use tobacco and are pregnant:</p> <ul style="list-style-type: none"> The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits. <p>You are covered for an additional smoking cessation benefit:</p> <ul style="list-style-type: none"> If you use tobacco the plan will cover a total of six counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. 	<p>\$0 copay</p> <p>*Referral may be required</p>





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Services that our plan pays for	What you must pay
<p>COVID-19 diagnosis, treatment & care package</p> <p>Covered services include:</p> <p>One Health Essentials Kit per year. Kit includes over-the-counter items useful for preventing the spread of COVID-19 and other viruses.</p> <p>Medicare-covered Antibody and Diagnostic Testing:</p> <ul style="list-style-type: none"> • Testing is covered when medically necessary and ordered by a physician. Coverage amount is not to exceed Humana contracted rate or Medicare allowable charges. <p>Treatment for confirmed COVID-19 Diagnosis:</p> <ul style="list-style-type: none"> • Hospitalization, medical services, and FDA approved prescription drugs for the treatment of COVID-19 • Home delivered meals - 14 days (28 meals) <p>Contact plan for details.</p>	<p>\$0 Copay</p> <p>*Prior authorization may be required</p>
<p>Crisis services</p> <p>The health plan is expanding services to include Mobile Crisis Response (MCR) and Crisis Stabilization services. Crisis Services (Expanded) may be provided for up to 30 days following an MCR event to prevent additional behavioral health crises.</p> <p>To access MCR services, health plan members or individuals concerned about health plan members should call the state's crisis intake line, CARES, at 1-800-345-9049 (TTY: 1-866-794-0374). CARES will dispatch a local provider to the location of the health plan member in crisis.</p> <p>The health plan will cover Mobile Crisis Response and Crisis Stabilization services provided by:</p> <ul style="list-style-type: none"> • Community Mental Health Centers with a crisis certification from the state, or • Behavioral Health Clinics with a crisis certification from the state. 	<p>\$0 copy</p>




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Services that our plan pays for	What you must pay
<p>Dental services</p> <p>The plan covers the following dental services:</p> <ul style="list-style-type: none"> • Limited and comprehensive exams • Restorations • Dentures • Extractions • Sedation • Dental emergencies • Dental services necessary for the health of a pregnant woman prior to delivery of her baby <p>You are covered for the following additional dental benefits:</p> <ul style="list-style-type: none"> – 1 Comprehensive oral evaluation every six months – 1 Prophylaxis (cleaning) every six months 	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> Depression screening</p> <p>The plan will cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.</p>	<p>\$0 copay</p>
<p> Diabetes screening</p> <p>The plan will cover this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p> Diabetic self-management training, services, and supplies</p> <p>The plan will cover the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> 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 cover the following: <ul style="list-style-type: none"> 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) <p>The plan will also cover fitting the therapeutic custom-molded shoes or depth shoes.</p> <ul style="list-style-type: none"> The plan will cover training to help you manage your diabetes, in some cases. 	<p>\$0 copay</p> <p>*Prior authorization may be required</p>



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Services that our plan pays for	What you must pay
<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a provider trained to give emergency services, and • needed to treat a medical emergency. <p>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:</p> <ul style="list-style-type: none"> • serious risk to your health or to that of your unborn child; 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, when: <ul style="list-style-type: none"> ◦ there is not enough time to safely transfer you to another hospital before delivery. ◦ a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. <p>Emergency care is limited to within the U.S. and its territories.</p>	<p>\$0 copay</p> <p>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 in order 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.</p>





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Services that our plan pays for	What you must pay
<p>Family planning services</p> <p>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.</p> <p>The plan will cover the following services:</p> <ul style="list-style-type: none"> • 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 • Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy. <p>The plan will also cover some other family planning services. However, you must see a provider in the plan's network for the following services:</p> <ul style="list-style-type: none"> • 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* 	<p>\$0 copay</p> <p>*Prior authorization is required for infertility and genetic testing</p>



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Services that our plan pays for	What you must pay
<p>Gender-affirming Services</p> <p>For members with a diagnosis of gender dysphoria, the plan covers gender-affirming services. Some screenings and services are subject to prior authorization and referral requirements.</p>	<p>\$0 copay</p>
<p> Health and wellness education programs</p> <p>The plan provides the following services:</p> <ul style="list-style-type: none"> • Online and printed health education materials and tools • Nutrition counseling • Disease management programs 	<p>\$0 copay</p>
<p>Hearing services</p> <p>The plan covers 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.</p> <p>The plan also covers the following:</p> <ul style="list-style-type: none"> • Basic and advanced hearing tests • Hearing aid counseling • Fitting/evaluation for a hearing aid • Hearing aids once every three years • Hearing aid batteries and accessories • Hearing aid repair and replacement of parts. 	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> HIV screening</p> <p>The plan pays for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • ask for an HIV screening test, or • are at increased risk for HIV infection. <p>For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Home health agency care</p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.</p> <p>The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p>Home infusion therapy</p> <p>The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; and • Supplies, such as tubing or a catheter. <p>The plan will cover home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; and • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. 	<p>\$0 copay</p> <p>*Prior authorization may be required</p>




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Services that our plan pays for	What you must pay
<p>Hospice care</p> <p>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.</p> <p>The plan will cover the following while you are getting hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care, including home health aide services • Occupational, physical and speech-language therapy services to control symptoms • Counseling services. <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare:</p> <ul style="list-style-type: none"> • See Section F of this chapter for more information. <p>For services covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • Humana Gold Plus Integrated (Medicare-Medicaid Plan) will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. <p>This benefit is continued on the next page.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Hospice care (continued)</p> <p>For drugs that may be covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, page 98. <p>Note: If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. To talk with a care coordinator, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.</p>	
<p> Immunizations</p> <p>The plan will cover the following services:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, each flu season, in the fall and winter, with additional flu shots if medically necessary • 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 <p>The plan will cover other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D, page 105 to learn more.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Inpatient hospital care</p> <p>The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • Blood, including storage, blood components and administration thereof • Physician services. <p>This benefit is continued on the next page.</p>	<p>\$0 copay</p> <p>You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.</p> <p>*Prior authorization is required</p>



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Services that our plan pays for	What you must pay
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. <p>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 outside the pattern of care for your community. If Humana Gold Plus Integrated (Medicare-Medicaid Plan) provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for reasonable lodging and travel costs for you and one other person.</p>	
<p>Inpatient mental health care</p> <p>The plan will cover medically necessary psychiatric inpatient care at approved institutions.</p>	<p>\$0 copay</p> <p>*Prior authorization is required</p>




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Services that our plan pays for	What you must pay
<p>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</p> <p>If your inpatient stay is not reasonable and necessary, the plan will not pay for it.</p> <p>However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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 	<p>\$0 copay</p> <p>*Prior authorization is required</p>



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Services that our plan pays for	What you must pay
<p>Kidney disease services and supplies</p> <p>The plan will cover the following services:</p> <ul style="list-style-type: none"> • 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 28. • 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 <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> Lung cancer screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • 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. <p>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.</p>	<p>\$0 copay</p> <p>*Referral may be required</p>





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Services that our plan pays for	What you must pay
<p>Medical equipment and related supplies</p> <p>The following general types of services and items are covered:</p> <ul style="list-style-type: none"> • Nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy • Durable medical equipment (DME), such as wheelchairs, crutches, power mattress systems, diabetic supplies, walkers, hospital beds ordered by a provider for use in the home, Intravenous (IV) infusion pumps, humidifiers, speech generating devices, and walkers (for a definition of “Durable medical equipment,” see Chapter 12, page 179 of this handbook) • Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts • Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment • Repair of durable medical equipment, prosthetic devices and orthotic devices • Rental of medical equipment under circumstances where patient’s needs are temporary <p>To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.</p> <p>We will pay for all medically necessary DME 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.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>



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Services that our plan pays for	What you must pay
<p> Medical nutrition therapy</p> <p>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.</p> <p>The plan will cover 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 cover 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.</p>	<p>\$0 copay</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle. 	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. Any of the following Part B drug categories below may be subject to Part B step therapy. Humana Gold Plus Integrated (Medicare-Medicaid Plan) will cover the following drugs:</p> <ul style="list-style-type: none"> • 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 necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.humana.com/PAL</p> <p>Chapter 5, Section Introduction, page 87 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6, Section Introduction, page 101 explains what you pay for your outpatient prescription drugs through our plan.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>




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Services that our plan pays for	What you must pay
<p>Non-emergency transportation</p> <p>The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of non-emergency transportation include:</p> <ul style="list-style-type: none"> • Medicare • Non-emergency ambulance • Service car • Taxicab <p>Unlimited round trip(s) per year by taxi, bus/subway, van, medical transport for trips allowed to nursing homes, to the pharmacy right after doctor visits, and other medical providers and locations.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Non-Medicaid Over-the-Counter Drugs</p> <p>You are eligible for up to \$30 quarterly 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.</p>	<p>\$0 copay</p>
<p>Nurse Advice Call Line (HumanaFirst®)</p> <p>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 1-855-235-8530 (TTY: 711). The call is free. It's staffed by nurses who can help address your immediate health concerns and answer questions about particular medical conditions.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Nursing facility (NF) care and skilled nursing facility (SNF) care</p> <p>The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The plan will pay for the following services and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically needed, maintenance and cleaning • Meals, including special meals, food substitutes, and nutritional supplements • Nursing services and resident supervision/oversight • Physician services • Physical therapy, occupational therapy, and speech therapy • Drugs, and other medications available through a pharmacy without a prescription, ordered by your doctor as part of your plan of care, including over-the-counter medications and their administration • Non-custom durable medical equipment (such as wheelchairs and walkers) • Medical and surgical supply items (such as bandages, oxygen administration supplies, oral care supplies and equipment, one tank of oxygen per resident per month) • Additional services provided by a nursing facility in compliance with state and federal requirements <p>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:</p> <ul style="list-style-type: none"> • 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) <p>A nursing facility where your spouse lives at the time you leave the hospital.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>When your income exceeds an allowable amount, you must contribute toward the cost of services. This is known as the patient pay amount and is required if you live in a nursing facility. However, you may not end up having to pay an amount each month.</p> <p>Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.</p>
<p> Obesity screening and therapy to keep weight down</p> <p>If you have a body mass index of 30 or more, the plan will cover 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.</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Opioid treatment program</p> <p>The plan will pay for the following services to treat opioid use disorder:</p> <ul style="list-style-type: none"> • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) 	<p>\$0 copay</p>
<p>Outpatient diagnostic tests and therapeutic services</p> <p>The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Lab tests • Blood, blood components and administration thereof • Other outpatient diagnostic tests 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>



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Services that our plan pays for	What you must pay
<p>Outpatient hospital services</p> <p>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.</p> <p>The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery <ul style="list-style-type: none"> ◦ Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” ◦ Sometimes you can be in the hospital overnight and still be an “outpatient.” ◦ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf • 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 • Preventive screenings and preventive services listed throughout the Benefits Chart • Some drugs that you can’t give yourself 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>



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Services that our plan pays for	What you must pay
<p>Outpatient mental health care</p> <p>The plan will cover mental health services provided by:</p> <ul style="list-style-type: none"> • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, • a licensed clinical professional counselor, • Community Mental Health Centers (CMHCs), • Behavioral Health Clinics (BHCs), • Hospitals, • Encounter rate clinics such as Federally Qualified Health Centers (FQHCs), or • any other Medicare-qualified mental health care professional as allowed under applicable state laws. <p>The plan will cover the following types of outpatient mental health services:</p> <ul style="list-style-type: none"> • Clinic services provided under the direction of a physician • Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as Integrated Assessment and Treatment Planning, crisis intervention, therapy, and case management • Day treatment services • Outpatient hospital services, such as Clinic Option Type A and Type B services <p>The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with federal and state laws and all applicable policies and/or agreements.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>




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Services that our plan pays for	What you must pay
<p>Outpatient mental health crisis services (expanded)</p> <p>The crisis service array is expanded to include Mobile Crisis Response (MCR) and Crisis Stabilization services. MCR services require face-to-face screening using the state-approved crisis screening instrument. Following the completion of the MCR event, transition to additional crisis or other rehabilitation services, consistent with state regulations, to ameliorate the crisis situation may occur. The state's centralized crisis intake line, CARES, accepts referrals for MCR services on behalf of beneficiaries experiencing a behavioral health crisis. Crisis Stabilization services may be provided for up to 30 days following an MCR event and require a demonstrated need for ongoing stabilization supports as documented on an LPHA-approved crisis safety plan.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Outpatient rehabilitation services</p> <p>The plan will cover physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Outpatient surgery</p> <p>The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Partial hospitalization services</p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service 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.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>



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Services that our plan pays for	What you must pay
 Physical exam (Routine) In addition to the “Annual Wellness Exam” preventive visit, you are covered for the following exam once per year: <ul style="list-style-type: none"> • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions. 	\$0 copay
Physician/provider services, including doctor’s office visits The plan will cover the following services: <ul style="list-style-type: none"> • Medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> ◦ 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 including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare. • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ◦ you’re not a new patient and ◦ the check-in isn’t related to an office visit in the past 7 days and ◦ the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment <p>This benefit is continued on the next page.</p>	\$0 copay *Prior authorization and/or referral may be required




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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor's office visits <i>(continued)</i></p> <ul style="list-style-type: none"> • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ◦ you're not a new patient and ◦ the evaluation isn't related to an office visit in the past 7 days and ◦ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before a medical procedure • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> ◦ 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. 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>




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<p>Podiatry services</p> <p>The plan will cover the following services:</p> <ul style="list-style-type: none"> • 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 <p>You are also covered for additional podiatry benefits. You may self-refer for six visits per year to a network specialist for the services below:</p> <ul style="list-style-type: none"> – Treatment of flat feet or other structural misalignments of the feet – Removal of corns – Removal of warts – Removal of calluses – Hygienic care 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Post-Discharge Meal Program</p> <p>After an inpatient stay in either the hospital or a nursing facility, you are eligible to receive two meals per day for five 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.</p> <p>Please contact Well Dine at 1-866-96Meals (1-866-966-3257) TTY 711 for further details or to take advantage of this benefit after your discharge. The call is free.</p>	<p>\$0 copay</p> <p>*Prior authorization may be required</p>
<p> Prostate cancer screening exams</p> <p>The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for:</p> <ul style="list-style-type: none"> • Men age 50 and older • African American men age 40 and older • Men age 40 and older with a family history of prostate cancer 	<p>\$0 copay</p>



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<p>Prosthetic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. The plan will cover the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • 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) <p>The plan will also cover some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.</p> <p>The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section on page 80 for details.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Pulmonary rehabilitation services</p> <p>The plan will cover 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.</p>	<p>\$0 copay</p> <p>* Referral may be required.</p>
<p> Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan will cover 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.</p> <p>The plan will also cover 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 cover 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.</p>	<p>\$0 copay</p>



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<p>Substance abuse services</p> <p>The plan will cover substance abuse services provided by:</p> <ul style="list-style-type: none"> • A state-licensed substance abuse facility or • Hospitals. <p>The plan will cover the following types of medically necessary substance abuse services:</p> <ul style="list-style-type: none"> • Outpatient services (group or individual), such as assessment, therapy, medication monitoring, and psychiatric evaluation, • Medication Assisted Treatment (MAT) for opioid dependency, such as ordering and administering methadone, managing the care plan, and coordinating other substance use disorder services, • Intensive outpatient services (group or individual), • Detoxification services, and • Some residential services, such as short-term Rehabilitation Services. 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p>
<p>Supervised exercise therapy (SET)</p> <p>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:</p> <ul style="list-style-type: none"> • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider' <p>The SET program must be:</p> <ul style="list-style-type: none"> • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques 	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
<p>Urgently needed care</p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none">• a non-emergency, or• a sudden medical illness, or• an injury, or• a condition that needs care right away. <p>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.</p> <p>You are covered for urgently needed care in the US and its territories.</p>	<p>\$0 copay</p>




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Services that our plan pays for	What you must pay
<p>Vision care</p> <p>The plan covers the following:</p> <ul style="list-style-type: none"> • Annual routine eye exams <ul style="list-style-type: none"> ◦ Eye glasses (lenses and frames) ◦ Frames limited to one pair in a 24 month period • Lenses limited to one pair in a 24 month period, but you may get more when medically necessary, with prior approval • Custom-made artificial eye • Contacts and special lenses when medically necessary, with prior approval <p>To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.</p> <p>The plan covers 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.</p> <p>For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, and • Hispanic Americans who are 65 or older. <p>The plan covers 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.)</p>	<p>\$0 copay</p>



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Services that our plan pays for	What you must pay
 “Welcome to Medicare” Preventive Visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes: <ul style="list-style-type: none"> • 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. <p>Note: 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.</p>	\$0 copay

Home and community-based services that our plan covers	What you must pay
Adult day service The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: <ul style="list-style-type: none"> • Provides personal attention • Promotes social, physical and emotional well-being. 	\$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Assisted living If you qualify, the Supportive Living Facility provides an alternative to Nursing Facility placement. Some of the services include the following: <ul style="list-style-type: none"> • Assistance with activities of daily living • Nursing services • Personal care • Medication administration • Housekeeping • 24 hour response/security staff 	\$0 copay *Prior authorization and/or referral may be required *Waiver may be required



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For more information, visit [Humana.com](https://www.humana.com).

Home and community-based services that our plan covers	What you must pay
<p>Habilitation - day</p> <p>The plan covers day habilitation, which assists with the retention or improvement in self help, socialization and adaptive skills outside the home if you qualify.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Home delivered meals</p> <p>The plan covers prepared meals brought to your home if you qualify.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Home health aide</p> <p>The plan covers services from a home health aide, under the supervision of a registered nurse (RN) or other professional, if you qualify. Services may include the following:</p> <ul style="list-style-type: none"> • Simple dressing changes • Assistance with medications • Activities to support skilled therapies • Routine care of prosthetic and orthotic devices 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Home modifications</p> <p>The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:</p> <ul style="list-style-type: none"> • Ramps • Grab-bars • Doorway widening 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>



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For more information, visit [Humana.com](https://www.humana.com).

Home and community-based services that our plan covers	What you must pay
<p>Homemaker services</p> <p>The plan covers home care services provided in your home or community if you qualify. These services may include the following:</p> <ul style="list-style-type: none"> • A worker to help you with laundry • A worker to help you with cleaning • Training to improve your community living skills 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Nursing services</p> <p>The plan covers shift and intermittent nursing services by a registered nurse (RN) or licensed practical nurse (LPN) if you qualify.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Personal assistant</p> <p>The plan covers a personal assistant to help you with activities of daily living if you qualify. These include, for example:</p> <ul style="list-style-type: none"> • Bathing • Feeding • Dressing • Laundry 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Personal emergency response system</p> <p>The plan covers an electronic in home device that secures help in an emergency if you qualify.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Respite care</p> <p>The plan covers respite services to provide relief for an unpaid family member or primary caregiver who meet all of your service needs if you qualify. Certain limitations apply.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>



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Home and community-based services that our plan covers	What you must pay
<p>Specialized durable medical equipment and supplies</p> <p>If you qualify, the plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:</p> <ul style="list-style-type: none"> • Hoyer lift • Shower benches/chairs • Stair lift • Bed rails 	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>
<p>Therapies</p> <p>The plan covers occupational, physical, and speech therapy if you qualify. These therapies focus on long term habilitative needs rather than short term acute restorative needs.</p>	<p>\$0 copay</p> <p>*Prior authorization and/or referral may be required</p> <p>*Waiver may be required</p>



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

E. Benefits covered outside of Humana Gold Plus Integrated (Medicare-Medicaid Plan)

The following services are not covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) but are available through Medicare.

E1. Hospice Care

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.

See the Benefits Chart in Section C of this chapter for more information about what Humana Gold Plus Integrated (Medicare-Medicaid Plan) pays for while you are receiving hospice care services.

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.

For drugs that may be covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, page 98.

Note: If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

To talk with a care coordinator, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

F. Benefits not covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan), Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover 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 cover 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 cover a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section D, page 125.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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 Chapter 3, page 40 -41 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 necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- 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.
- 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.
- 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 cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Radial keratotomy, LASIK surgery, and other low-vision aids. However, the plan will pay for glasses after cataract surgery.
- Reversal of sterilization procedures.
- 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.



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Chapter 5: Getting your outpatient prescription drugs through the plan

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, page 101 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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 C, page 44.

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 network 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 Chapter 9, page 141 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 medical references.

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For more information, visit **Humana.com**.

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For more information, visit **Humana.com**.

A. Getting your prescriptions filled

A1. Filling 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 or your care coordinator.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card** at your network pharmacy. The network pharmacy will bill Humana Gold Plus Integrated (Medicare-Medicaid Plan) for your covered prescription drug.

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. If you cannot pay for the drug, contact Customer Care 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 107.
- If you need help getting a prescription filled, you can contact Customer Care or your care coordinator.

A3. What to do if you 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 there are any refills left.

If you need help changing your network pharmacy, you can contact Customer Care or your care coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy. We will send you a notice before we make a change that affects you.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care coordinator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.



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- 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.
- 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 or your care coordinator.

A6. Using 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. A 90-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

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.

Mail-order processes

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

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before 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.

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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

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 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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

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 provide us your communication preference by signing into your Humana Pharmacy Account and go to "Preferences" under the "My Account" menu. You can call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

A7. Getting 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 one-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 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

A8. Using 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 have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

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 to see if there is a network pharmacy nearby.

A9. Paying 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 when you get your prescription. You can ask us to pay you back.

To learn more about this, see Chapter 7, Section A, page 107.

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.

B1. Drugs 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.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Customer Care.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B2. How to find a drug 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 to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are 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 (Medicare-Medicaid Plan) 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 D, page 125.)

Here are three general rules for excluded drugs:

1. 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 under our plan's medical benefit by Humana Gold Plus Integrated (Medicare-Medicaid Plan) for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references 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 the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, 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



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For more information, visit **Humana.com**.

B4. Drug List tiers

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

- Tier 1 – Generic drugs
- Tier 2 – Brand drugs
- Tier 3 – Non-Medicare Rx drugs
- Tier 4 – Non-Medicare over-the-counter (OTC) drugs

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

Chapter 6 Section C, page 104 tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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 plan expects your provider to prescribe 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 F, page 141.

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.

2. Getting plan approval in advance

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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

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 or check our website at **Humana.com**.

D. Reasons 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.

D1. Getting 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.
 - 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 days.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to the plan.
 - 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 30 days.
 - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
 - Long-term care pharmacies may provide your prescription drug in small 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 temporary 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.

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 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- 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 F2, page 140.

If you need help asking for an exception, you can contact Customer Care or your care coordinator.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Humana Gold Plus Integrated (Medicare-Medicaid Plan) may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval for a drug. (Prior approval is permission from Humana Gold Plus Integrated (Medicare-Medicaid Plan) before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits.)
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, see Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s up to date Drug List online at **Humana.com** or
- Call Customer Care to check the current Drug List at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes along that works as well as a drug on the Drug List now. When that happens, we may remove the current drug, but your cost for the new drug will stay the same or will be lower.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We will send you a notice with the steps you can take to ask for an exception. Please see Chapter 9 of this handbook for more information on exceptions.
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. If you are not notified, contact your prescribing doctor.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is new to the market **and**
 - Replace a brand name drug currently on the Drug List **or**
 - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. He or she can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, see Chapter 9.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**. For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug or the rest of the year.

F. Drug coverage in special cases

F1. 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

F2. 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.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, see Chapter 4, section C, page 59.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

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 or your care coordinator.

G3. Drug management program to help members safely use their opioid medications

Humana Gold Plus Integrated (Medicare-Medicaid Plan) has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, see Chapter 9, Section 3, page 125.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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

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.

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 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. 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 89 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 89.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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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 has more information about the drugs you take. 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B. How to keep 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 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 the drug, see Chapter 7, Section B, page 109.

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 an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

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. Be sure to keep these reports. They are an important record of your drug expenses.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

C. You pay nothing for a one-month or long-term supply of drugs

With Humana Gold Plus Integrated (Medicare-Medicaid Plan), you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of four tiers. You have no copays for prescriptions and OTC drugs on the Humana Gold Plus Integrated (Medicare-Medicaid Plan) Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are generic drugs and have a \$0 copay.
- Tier 2 drugs are brand name drugs and have a \$0 copay.
- Tier 3 are covered, non-Medicare Rx drugs and have a \$0 copay.
- Tier 4 drugs are non-Medicare over-the-counter (OTCs) and have a \$0 copay.

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

C2. 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 89 to find out when we will do that.

To learn more about these pharmacy choices, see Chapter 5, Section A, page 89 in this handbook and the plan's *Provider and Pharmacy Directory*.

C3. 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. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, see Chapter 5, Section C, page 94 or the *Provider and Pharmacy Directory*.

C4. What you pay

You can contact Customer Care to find out how much your copay is for any covered drug.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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

	A network pharmacy A one-month or up to a 90-day supply	The plan's mail-order service A one-month or up to a 90-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 30-day supply. Coverage is limited to certain cases. See Chapter 5, page 87 for details.
Tier 1 (Generic drugs)	\$0	\$0	\$0	\$0
Tier 2 (Brand drugs)	\$0	\$0	\$0	\$0
Tier 3 (Non-Medicare Rx drugs)	\$0	\$0	\$0	\$0
Tier 4 (Non-Medicare OTC drugs)	\$0	\$0	\$0	\$0

For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory*.

D. 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.

D1. What you need to know before you get a vaccination

We recommend that you call us first at Customer Care whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- 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 (Medicare-Medicaid Plan) to ensure that you do not have any upfront costs for a Part D vaccine.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, see Section B, page 109.

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

Contact Customer Care or your care coordinator if you have any questions. 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. 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 for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill the plan. Show your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Customer Care if you get any bills.**

- Because Humana Gold Plus Integrated (Medicare-Medicaid Plan) pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, 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, send us the bill and proof of any payment you made. We will pay you back for your covered services.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 89 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 Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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.

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 7, Section C, page 109.
 - 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 F, page 141.
- 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 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 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 F1, page 139.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B. Sending a request for payment

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 coordinator 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 www.humana.com/medicare/medicaid-dual/illinois/pharmacy/, or you can call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time and ask for the form. The call is free.

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 within 90 days of the date you got the service, item or drug.

C. Coverage decisions

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 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, page 28 explains the rules for getting your services covered. Chapter 5, page 89 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for 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 D, page 125.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

D. Appeals

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 D, page 125.

- If you want to make an appeal about getting paid back for a health care service, go to page 138.
- If you want to make an appeal about getting paid back for a drug, go to page 139.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

A. Your 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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. Spanish materials are available upon request. You can make a standing request to get materials, now and in the future, in a language other than English. We will keep your preferred language other than English and/or alternate format for future mailings and communications. You will not need to make a separate request each time. Call Customer Care if you want to change your standing request at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
- 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, 7 days a week. TTY users should call 1-877-486-2048. You can also file a complaint with Medicaid by calling the Illinois Health Benefits Hotline at 1-800-226-0768. TTY users should call 1-877-204-1012.

Tenemos que informarle sobre los beneficios del plan y sus derechos de una forma que usted pueda comprender. Tenemos que informarle sobre sus derechos cada año que usted sea afiliado de nuestro plan.

- Para obtener información en una forma que pueda comprender, llame al Servicio al Cliente. Nuestro plan tiene personal que puede responder preguntas en diferentes idiomas. Ofrecemos materiales en español a solicitud. El Servicio al Cliente también ofrece servicios de intérpretes de idiomas gratuitos para las personas que no hablan inglés. Comuníquese con el Servicio al Cliente al 1-800-787-3311 (TTY: 711). Estamos disponibles los 7 días de la semana, de 8 a.m. a 8 p.m. Sin embargo, tenga en cuenta que nuestro sistema telefónico automatizado puede responder su llamada durante los fines de semana y días feriados desde el 15 de febrero hasta el 30 de septiembre. Puede dejar su nombre y número de teléfono y le llamaremos en el transcurso del siguiente día laborable. La llamada es gratis. Visite **Humana.com** para acceder, las 24 horas, a información como historial de reclamaciones, elegibilidad, lista de medicamentos de Humana, la herramienta de búsqueda de proveedores Physician Finder o noticias e información sobre la salud. También podemos brindarle información en braille o letras grandes. Puede solicitar formatos alternativos si llama al Servicio al Cliente.
- Si tiene dificultades para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad, y quiere presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede llamar a la Línea directa de beneficios de salud de Illinois al 1-800-226-0768 para presentar una queja ante Medicaid. Los usuarios de TTY deben llamar al 1-877-204-1012.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B. Our responsibility to 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. You can find more information about choosing a PCP in Chapter 3, page 32.
 - Call Customer Care or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to go to a women's health specialist without getting a referral. A referral is approval from your PCP to see someone that is not your PCP.
- 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 30.

Chapter 9, Section J, page 158 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 E, page 131 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

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

Your PHI 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 PHI 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 PHI.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

C1. How we protect your PHI

We make sure that unauthorized people do not see or change your records.

In most situations, we do not give your PHI 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 PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

C2. 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 PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

For more information on privacy practices, see Chapter 11, Section D, page 171.

D. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Humana Gold Plus Integrated (Medicare-Medicaid Plan), 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 1-800-787-3311 (TTY: 711) Monday – Friday, from 8 a.m. – 8 p.m. Central time. This is a free service. You may contact Humana Gold Plus Integrated (Medicare-Medicaid Plan) to request plan materials in any language. Customer Care also has free language interpreter services available for non-English speakers. Please contact our Customer Care number at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We can also give you information in large print, braille, or audio. You can request alternative formats by calling Customer Care.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

It is important to understand that before you get a service or a drug, we have to make sure that you need the service or drug and that it is medically right for you. This is called utilization management. To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. Rewards are not given to doctors, other health care providers or individuals who make these decisions or for denying coverage of services. Any rewards for these decision makers do not encourage decisions that result in under use of services.

If you want information about any of the following, call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

- How to choose or change plans
- 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
- Our network providers and our network pharmacies, including:
 - How to choose or change primary care providers
 - 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 *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free, or visit our website at **Humana.com**.
- 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
- Why something is not covered and what you can do about it, including asking us to:
 - Put in writing why something is not covered
 - Change a decision we made
 - Pay for a bill you got



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

E. Inability of network providers to 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 A, page 107.

F. Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- 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 your Medicare benefits through:
 - A different Medicare-Medicaid plan
 - Original Medicare
 - A Medicare Advantage plan
- You can get your Medicare Part D prescription drug benefits from:
 - A different Medicare-Medicaid plan
 - A prescription drug plan
 - A Medicare Advantage plan
- See Chapter 10 Section D1, page 164 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You can get your Medicaid benefits through:
 - A different Medicare-Medicaid plan
 - Medicaid fee-for-service or a Medicaid Managed Long-Term Services and Supports (MLTSS) plan

NOTE: If you are getting long-term care or home and community based waiver services, you must either stay with our plan or choose another plan to receive your long-term supports and services.

- To choose a HealthChoice Illinois Managed Long-Term Services and Supports plan (MLTSS), you can call Illinois Client Enrollment Services at 1-877-912-8880 from 8 a.m. to 6 p.m. Central time, Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Humana Gold Plus Integrated (Medicare-Medicaid Plan) and join a HealthChoice Illinois Managed Long-Term Services and Supports health plan (MLTSS). If you don't pick a health plan, you will be assigned to our company's HealthChoice Illinois MLTSS plan. See Chapter 10 for more information.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

G. Your right to make decisions about your health care

G1. Your 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. You have the right to:

- **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.
- **Get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **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.
- **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.
- **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 D2, page 126 tells how to ask the plan for a coverage decision.

G2. Your 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. To learn more about advance directives in Illinois, go to the Illinois Department of Public Health’s website at: www.idph.state.il.us/public/books/advin.htm.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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 a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid (Illinois Department of Public Health (IDPH), Illinois Department of Aging (IDoA) and Area Agencies on Aging) 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.
- **Humana Gold Plus Integrated (Medicare-Medicaid Plan) will make your completed form part of your medical record.** Humana Gold Plus Integrated (Medicare-Medicaid Plan) cannot, as a condition of treatment, require you to fill out or waive an advance directive.
- 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.

G3. 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 by calling the Senior Helpline at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call is free.

H. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section A, page 124 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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly—and it is **not** about discrimination for the reasons listed in chapter 11 of this handbook — or would like more information about your rights, you can get help by calling:

- Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
- The Senior Health Insurance Program at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call is free. For details about this organization and how to contact it, see Chapter 2, Section E, page 19.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The Senior Helpline at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call is free.

I. Your 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.

- **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 28 and Chapter 4, Section C, page 44. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
 - Covered drugs, see Chapter 5, Section B, page 92 and Chapter 6, Section Introduction, page 101.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time if you have other coverage. The call is free.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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.
- **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 (Medicare-Medicaid Plan) members, Medicaid pays for your Part A premium and for your Part B premium.
 - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Section F5, 144 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
 - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Humana Gold Plus Integrated (Medicare-Medicaid Plan). Chapter 1, Section D, page 5 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 20 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 1-800-787-3311 (TTY: 711, Monday – Friday, from 8 a.m. – 8 p.m. Central Time for help if you have questions or concerns, or if you have recommendations about your rights and responsibilities. The call is free..



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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

Introduction

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 Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327.** This chapter explains the options you have for different problems and complaints, but you can always call the Senior HelpLine to help guide you through your problem. The Senior Helpline will help anyone at any age enrolled in this plan. For additional resources to address your concerns and ways to contact them, see Chapter 2, Section J, page 22, for more information on ombudsman programs.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information,** visit **Humana.com**.

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For more information, visit **Humana.com**.

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For more information, visit **Humana.com**.

A: 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.

A1: 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,” “benefit determination,” “at-risk 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.

B: Where to call for help

B1: 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 Senior HelpLine

If you need help, you can always call the Senior HelpLine. The Senior HelpLine has an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Senior HelpLine 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 Senior HelpLine is 1-800-252-8966, TTY: 1-888-206-1327. You can call the Senior Help Line Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free and are available to you no matter how old you are. See Chapter 2, Section J, page 22, for more information on ombudsman programs.

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

You can also call the Senior Health Insurance Program (SHIP). SHIP counselors can answer your questions and help you understand what to do to handle your problem. SHIP counselors can help you no matter how old you are. The SHIP is not connected with us or with any insurance company or health plan. The SHIP phone number is 1-800-252-8966, TTY: 1-888-206-1327. The call and help are free.

Getting help from Medicare



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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 at www.medicare.gov.

Getting help from Medicaid

You can call the State of Illinois directly for help with problems. Call the Illinois Department of Healthcare and Family Services Health Benefits Hotline at 1-800-226-0768, TTY: 877-204-1012 Monday through Friday from 8:00 a.m. to 4:30 p.m. The call is free.

C: Problems with your Benefits

C1: Using the process for coverage decisions and appeals or for making 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.)	
<p>Yes.</p> <p>My problem is about benefits or coverage.</p> <p>Go to Section D, “Coverage decisions and appeals” on page 125</p>	<p>No.</p> <p>My problem is not about benefits or coverage.</p> <p>Skip ahead to Section J “How to make a complaint” on page 158</p>

D: Coverage decisions and appeals

D1: 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 have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. For more information, visit Humana.com.

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.

D2: 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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.
- Call the **Illinois Department of Healthcare and Family Services Health Benefits Hotline** for free help Monday through Friday from 8:00 a.m. to 4:30 p.m. The Illinois Health Benefits Hotline helps people enrolled in Medicaid with problems. The phone number is 1-800-226-0768, TTY: 1-877-204-1012.
- Call the **Senior HelpLine** for free help Monday through Friday from 8:30 a.m. to 5:00 p.m. The Senior Helpline will help anyone at any age enrolled in this plan. The Senior HelpLine is an independent organization. It is not connected with this plan. The phone number is 1-800-252-8966, TTY: 1-888-206-1327.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
 - If you want your doctor or other provider to be your representative, call Customer Care and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.
 - Note that under the Medicare program, your doctor or other provider can file an appeal without the "Appointment of Representative" form.
- 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. The form gives 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.

D3: Using the section of this chapter that 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 E on page 128** 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 our plan covers this care.
 - We did not approve services, or items, or drugs that your doctor wants to give you, and you believe that this care should be covered.
 - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* also known as the Drug List, with a (OTC) are **not** covered by Part D. See Section F on page 139 for Part D drug appeals.
 - You got medical care or services or items that you think should be covered, but we are not paying for this care.
 - You got and paid for medical 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 G and H on pages 147 and 152.
- **Section F on page 139** 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 Drug List.
 - You want to ask us to waive limits on the amount of the drug you can get.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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 G on page 147** 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 H on page 152** 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 1-800-787-3311 (TTY:711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

If you need other help or information, please call the Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327, Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

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

E1: 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, including Medicare Part B drugs. Drugs in the Drug List with a (OTC) are **not** covered by Part D. Use Section F 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 E2 on page 129 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 E3 on page 131 for information on making an appeal.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 E3 (on page 131) 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 E5 on page 138 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 E3 on page 131 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 G or H on pages 147 and 152 to find out more.

E2: 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: 1-800-787-3311, TTY: 711 We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.
- You can fax us at: 1-800-266-3022
- You can write 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 unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part prescription drug, we will give you a decision no more than 72 hours after we receive your request. 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 calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information,** visit **Humana.com**.

Can I get a Coverage Decision faster?

Yes. If you need a response faster because of your health, ask us to make a “fast coverage decision.” If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

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. We can’t take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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, or faxing our plan to ask us to cover the care you want.
- You can call us at 1-866-737-5113. For the details on how to contact us, go to Chapter 2, page 12.
- 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 already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) 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 (or the 72 hour deadline for Medicare Part B prescription drugs) 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 the fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section J on page 158.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com.**

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

You will be approved (pre-authorized) to get the service within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked unless your request is for a Medicare Part B prescription drug.

- If your request is for a Medicare Part B prescription drug, you will be approved (pre-authorized) to get the drug within 72 hours (for a standard coverage decision) or 24 hours (for a fast coverage decision).
- If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period. We can't take extra time to make our coverage decision for a Medicare Part B prescription drug.

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).

E3: 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 disagrees 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 Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The Senior HelpLine is not connected with us or with any insurance company or health plan. The call and help are free.

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.

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

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 Medicaid service you currently get will be changed or stopped, you have **10 calendar days** to appeal if you want to keep getting that Medicaid service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 1-800-787-3311. We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. For additional details on how to reach us for appeals, see Chapter 2, page 12.
- 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: Grievance and Appeal
PO Box 14546
Lexington, KY 40512-4546
 - You may also ask for an appeal by calling us at 1-800-787-3311. We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as 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, other provider, or someone else 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 a Appointment of Representative form, call Customer Care and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf: or our website at 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.

Note that under the Medicare program, your doctor or other provider can file an appeal without the Appointment of Representative form.

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. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a Medicaid service you currently get will be changed or stopped, you have **10 calendar days** to appeal if you want to keep getting that Medicaid service while your appeal is processing. Read “Will my benefits continue during Level 1 Appeals” on page 134 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Customer Care at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

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 15 business days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). 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 we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can’t take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- 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 J on page 158.
- If we do not give you an answer to your appeal within 15 business days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) 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 service or item covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service or item covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 of this chapter on page 134.

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 give you our answer (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

service or item covered by Medicare or both Medicare and Medicaid, 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 service or item covered only by Medicaid, 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 E4 on page 134.

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will let you know within 24 hours after we get your request if we need more information to decide your appeal. We will make a decision on your fast appeal within 24 hours after receiving all of the required information from you.

- 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - 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 J on page 158.
 - If we do not give you an answer to your appeal within 24 hours after receiving all required information 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 service or item covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service or item covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 on page 134.
- **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 make our decision.
- **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 service or item covered by Medicare or both Medicare and Medicaid, 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 service or item covered only by Medicaid, 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 E4 on page 134.

Will my benefits continue during Level 1 Appeals?

- If your problem is about a service covered by Medicare or both Medicare and Medicaid, your benefits for that service will continue during the Level 1 Appeal process.
- If your problem is about a service covered only by Medicaid, your benefits for that service will not continue unless you ask the plan to continue your benefits when you appeal. You must submit your appeal and ask to continue benefits within 10 calendar days after you receive the Notice of Denial of Medical Coverage. If you lose the appeal, you may have to pay for the service.

E4: 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 you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- 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 State Fair Hearings office. 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. If they also say **No** to your appeal, you can ask for another Level 2 Appeal with the State Fair Hearings office.

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 an Independent Review Entity (IRE) or it is a Medicaid State Fair Hearings office.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

Level 2 of the appeals process for Medicaid services is a State Fair Hearing. You must ask for a State Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 Appeal. The letter you get from us will tell you where to submit your hearing request.

- If you want to ask for a State Fair Hearing about a standard Medicaid item or service, the Aging Waiver (Community Care Program, or CCP), or the Supportive Living Facilities Waiver, submit your appeal in writing or over the phone to:

MAIL	Illinois Healthcare and Family Services Bureau of Administrative Hearings Fair Hearings Section 69 West Washington, 4th Floor Chicago, Illinois 60602
CALL	855-418-4421 (toll free)
TTY	800-526-5812
FAX	312-793-2005
EMAIL	HFS.FairHearings@Illinois.gov

- If you want to ask for a State Fair Hearing about the Persons with Disabilities Waiver, Traumatic Brain Injury Waiver, or the HIV/Aids Waiver (Home Services Program, or HSP), submit your appeal in writing or over the phone to:

MAIL	Department of Human Services Bureau of Hearings 69 West Washington, 4th Floor Chicago, Illinois 60602
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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

CALL	800-435-0774 (toll free)
TTY	877-734-7429
FAX	312-793-3387
EMAIL	DHS.HSPApeals@Illinois.gov

The hearing will be handled by an Impartial Hearing Officer authorized to oversee State Fair Hearings.

- You will get a letter from the Hearings office telling you the date, time, and place of the hearing. This letter will also provide detailed information about the hearing. It is important that you read this letter carefully.
- At least three business days before the hearing, you will get a packet of information from our plan. This packet will include all the evidence we will present at the hearing. This packet will also be sent to the Impartial Hearing Officer.
- You will need to tell the Hearings office of any reasonable accommodations you may need.
- If because of your disability you cannot participate in person at the local office, you may ask to participate by phone. Please provide the Hearings staff with the phone number to best reach you.
- You must provide all the evidence you will present at the hearing to the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear, as well as all documents you will use.
- The hearing will be recorded.

My problem is about a service or item that is covered by Medicare or both Medicare and Medicaid. What will happen at the Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicare or both Medicare and Medicaid, you will **automatically** get a Level 2 Appeal from the Independent Review Entity (IRE). The IRE will carefully review 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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

If you had a “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The IRE 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. The IRE can’t take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

How will I find out about the decision?

If your Level 2 Appeal was a State Fair Hearing, the State Fair Hearings office will send you a letter explaining its decision. This letter is called a “Final Administrative Decision.”

- If the State Fair Hearings office says **Yes** to part or all of what you asked for, we must authorize or provide the medical care coverage as soon as your health requires.
- If the State Fair Hearings office 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 in your standard appeal, 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 get 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 **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE’s decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 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.”

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 the State Fair Hearings office, and you disagree with the decision, you cannot make another appeal on the same issue to the State Fair Hearings office. The decision is reviewable only through the Circuit courts of the State of Illinois.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you may be able to appeal again in certain situations:

- If your problem is about a service or item that is covered by **both Medicare and Medicaid**, you can ask for another Level 2 Appeal with the State Fair Hearings office. After the IRE makes its decision, we will send you a letter telling you about your right to ask for a State Fair Hearing. Go to page 135 for information on the State Fair Hearing process.
- If your problem is about a service or item that is covered by **Medicare or by both Medicare and Medicaid**, you can appeal after Level 2 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 (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

See Section I on page 157 of this chapter for more information on your appeal rights after Level 2.

Will my benefits continue during Level 2 appeals?

Maybe.

- If your problem is about a service covered by Medicare only, your benefits for that service will **not** continue during the Level 2 appeals process with the IRE.
- If your problem is about a service covered by Medicaid only, your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan's decision letter.
- If your problem is about a service covered by both Medicare and Medicaid, your benefits for that service will continue during the Level 2 appeal process with the IRE. If you submit the appeal to the State Fair Hearings office after the IRE makes its decision and you would like for your services to stay in place during the State Fair Hearing process, you must ask for them to remain in place, and you must ask within 10 calendar days of the notice from the IRE.

E5: 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. You are never required to pay the balance of any bill.

If you get a bill 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 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 a service or item I paid for?

Remember, if you get a bill 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 the service or item within 60 calendar days after we get your request. If you haven't paid for the services or item 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Section E3 on page 131. 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 a service or item you 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 or both Medicare and Medicaid, 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.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid only, you can file a Level 2 Appeal yourself (see Section E4 on page 134).

F: Part D drugs

F1: 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 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 E on page 128.

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 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).



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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 determine which part 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 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.)	You can ask us for a coverage decision.	You can ask us to pay you back. (This is a type of coverage decision.)	You can make an appeal. (This means you are asking us to reconsider.)
Start with Section F2 on page 140 of this chapter. Also see Sections F3 and F4. on page 141.	Skip ahead to Section F4 on page 141.	Skip ahead to Section F4 on page 141.	Skip ahead to Section F5 on 144.

F2: What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List, or to use the drug without certain rules and limitations. If a drug is not on our Drug List, 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 Drug List.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on



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For more information, visit **Humana.com**.

our Drug List (for more information, go to Chapter 5, Section C, page 94).

- 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, we limit the amount of the drug you can have.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

F3: 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 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 F5 on 144 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4: 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 1-800-787-3311 (TTY: 711). We’re available Monday – Friday, from 8 a.m. – 8 p.m. Central time. However, please note that our



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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. The call is free. Visit **Humana.com** for 24 hour access to information such as 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.
 - Read Section D on page 125 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 109 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.

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

You can get a fast coverage decision **only if you are asking for a drug you have not yet received.**

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 calendar 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 section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

(You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have 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 J on page 158.

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 you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- **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 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.

F5: 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 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.
- 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 you 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.

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 section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

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 F4 on page 141.

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, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. 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, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2,



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 or 14 days if you asked us to pay you back for a drug you already bought.
 - 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.

F6: Level 2 Appeal for Part D drugs

If we say **No** to part of all of your appeal, you can choose whether to accept this decision or make 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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
- 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.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- 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 other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The **legal term** for an appeal to the IRE about a Part D drug is **“reconsideration.”**

Deadlines for “fast appeal” at Level 2



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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 Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- 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.

G: 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.

G1: 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. 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 1-800-787-3311 (TTY: 711). We’re available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana’s drug list. There you can also use the physician finder and get health news and information. 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 www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.
- If you need help, please call Customer Care or Medicare at the numbers listed above.

G2: 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 Illinois, the Quality Improvement Organization is called Livanta.

To make an appeal to change your discharge date call Livanta at:

Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775.

Call right away!

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at
Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775 and ask for a “fast review.”

Call before you leave the hospital and before your planned discharge date.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 G4, page 125.

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 at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call and help is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. You can also call the Senior HelpLine Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966, TTY: 1-888-206-1327. The call and help are free.

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 for 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

The legal term for this written explanation is called the **“Detailed Notice of Discharge.”**

You can get a sample by calling Customer Care at 1-800-787-3311 (TTY: 711) 24 hours a day, 7 days a week, Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. 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 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.

G3: 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 Illinois, the Quality Improvement Organization is called Livanta. You can reach Livanta at:
Toll-free Phone 1-888-524-9900 Toll-free TTY 1-888-985-8775.

- 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

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state
Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775
and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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.

G4: What happens if you 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.

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.

- 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.”
- **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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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 J on page 158 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.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our 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.

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.

H: 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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.

H1: We will tell you in advance when your coverage will be ending

- You will receive 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.

H2: 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 J on page 158 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 at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. Or call the Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327, Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

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

Toll-free Phone 1-888-524-9900

Toll-free TTY 1-888-985-8775

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.

During a Level 1 Appeal, The Quality Improvement



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com.**

Organization will review your appeal and decide whether to change the decision we made. In Illinois, the Quality Improvement Organization is called Livanta. You can reach Livanta at:
Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775. 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.

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 H4, page 156.

The legal term for the written notice is “**Notice of Medicare Non-Coverage.**”

To get a sample copy, call Customer Care at 1-800-787-3311 (TTY:711) Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. 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 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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.

H3: 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 Illinois, the Quality Improvement Organization is called Livanta. You can reach Livanta at:
Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775. 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.

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
Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775
and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- 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 got 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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

the details about how to go on to the next level of appeal, which is handled by a judge.

H4: What happens if you miss an appeal 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.

- 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.

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 J, on page 158 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

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.

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 Entity.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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.
- **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 our coverage of your services for as long as it is medically necessary.
- **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.

I: Taking your appeal beyond Level 2

I1: 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. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator 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 or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator’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 Senior HelpLine Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966, (TTY: 1-888-206-1327). The call and help are free.

I2: Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services that might be covered by Medicaid.

After your Level 2 Appeal in the State Fair Hearings office has concluded, you will receive a written decision called a “Final Administrative Decision.” This decision is made by the Director of the Agency based on recommendations from the Impartial Hearing Officer. The decision will be sent to you and all interested parties in writing by the Hearings office. This decision is reviewable only through the Circuit courts of the State



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

of Illinois. The time the Circuit Court will allow for filing for such review may be as short as 35 days from the date of your Final Administrative Decision.

J: How to make a complaint

J1. 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 (Medicare-Medicaid Plan) staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical 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.

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 Customer Care or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J2 on page 159.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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.

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 Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

J2: Internal complaints

- To make an internal complaint, call Customer Care at 1-800-787-3311 (TTY: 711) Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- You can send your complaint to us in writing at:
Humana Inc.
Attn: Grievance and Appeal
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 Gold Plus Integrated (Medicare-Medicaid Plan) will review the complaint and request any additional information. Humana Gold Plus Integrated (Medicare-Medicaid Plan) will notify you of the outcome of the complaint within 30 days of the receipt of complaint.
- 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.

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.

J3: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at:
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 users can call 1-877-486-2048. The call is free.

You can tell the Illinois Department of Healthcare and Family Services about your complaint



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

To file a complaint with the Illinois Department of Healthcare and Family Services, send an email to Aging.HCOProgram@illinois.gov.

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 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
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
1-800-368-1019
TTY 1-800-537-7697

You may also have rights under the Americans with Disability Act and under the Illinois Human Rights Act. You can contact the Senior HelpLine for assistance Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966, TTY: 1-888-206-1327. The call and help are free.

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** 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. To learn more about the Quality Improvement Organization, see Chapter 2.

In Illinois, the Quality Improvement Organization is called Livanta. The phone number for Livanta is Toll-free Phone 1-888-524-9900
Toll-free TTY 1-888-985-8775.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

A. When you can end your membership in our Medicare-Medicaid plan

You can ask to end your membership in Humana Gold Plus (Medicare-Medicaid Plan) at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

If you want to go back to getting your Medicare and Medicaid services separately:

- Your membership will end on the last day of the month that Illinois Client Enrollment Services or Medicare get your request to change your plan. Your new coverage will begin the first day of the next month. For example, if Illinois Client Enrollment Services or Medicare gets your request on January 18th, your new coverage will begin February 1st.

If you want to switch to a different Medicare-Medicaid Plan:

- If you ask to change plans before the 18th of the month, your membership will end on the last day of that same month. Your new coverage will begin the first day of the next month. For example, if Illinois Client Enrollment Services gets your request on August 6th, your coverage in the new plan will begin September 1st.
- If you ask to change plans after the 18th of the month, your membership will end on the last day of the following month. Your new coverage will begin the first day of the month after that. For example, if Illinois Client Enrollment Services gets your request on August 24th, your coverage in the new plan will begin October 1st.

If you leave our plan, you can get information about your:

- Medicare options in the table on page 165-166.
- Medicaid services on page 166.

You can get more information about when you can end your membership by calling:

- The Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m. Central time, Monday through Friday. TTY users should call 1-866-565-8576.
- The Senior Health Insurance Program (SHIP) at 1-800-252-8966 from 8:30 a.m. to 5 p.m., Monday through Friday. TTY users should call 1-888-206-1327.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you are in a drug management program, you may not be able to change plans. See Chapter 5, Section G3, page 100 for information about drug management programs.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

B. How to 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 (Medicare-Medicaid Plan):

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m. Central time, Monday through Friday. TTY users should call 1-866-565-8576; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking 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 165-166.

C. How to 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 Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m. Central time, Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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.
- If you are eligible for a Special Enrollment Period and Illinois Client Enrollment Services gets your request before the 18th of the month, your coverage with Humana Gold Plus Integrated (Medicare-Medicaid Plan) will end on the last day of that same month. If Illinois Client Enrollment Services gets your request after the 18th of the month, your coverage with Humana Gold Plus Integrated (Medicare-Medicaid Plan) will end on the last day of the following month. See Section A above for more information about when you can end your membership.

D. How to get Medicare and Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid plan after you leave Humana Gold Plus Integrated (Medicare-Medicaid Plan), you will go back to getting your Medicare and Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

<p>1. You can change to:</p> <p>A Medicare health plan, such as a Medicare Advantage plan or Programs of All-inclusive Care for the Elderly (PACE)</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">• Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call and help are free. <p>You will automatically be disenrolled from Humana Gold Plus Integrated (Medicare-Medicaid Plan) when your new plan's coverage begins.</p>
<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">• Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call and help are free. <p>You will automatically be disenrolled from Humana Gold Plus Integrated (Medicare-Medicaid Plan) when your Original Medicare coverage begins.</p>



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

<p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>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.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call your Senior Health Insurance Program (SHIP) at 1-800-252-8966. TTY users should call 1-888-206-1327.</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. <p>You will automatically be disenrolled from Humana Gold Plus Integrated (Medicare-Medicaid Plan) when your Original Medicare coverage begins.</p>
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D2. How to get your Medicaid services

If you leave the Medicare-Medicaid plan, you will either get your Medicaid services through fee-for-service or be required to enroll in the HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) program to get your Medicaid services.

If you are not in a nursing facility or enrolled in a Home and Community Based Services (HCBS Waiver), you will get your Medicaid services through fee-for-service. You can see any provider that accepts Medicaid and new patients.

If you are in a nursing facility or are enrolled in an HCBS waiver, you will be required to enroll in the HealthChoice Illinois MLTSS program to get your Medicaid services.

To choose a HealthChoice Illinois MLTSS health plan, you can call Illinois Client Enrollment Services at 1-877-912-8880 from 8 a.m. to 6 p.m. Central time, Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Humana Gold Plus Integrated (Medicare-Medicaid Plan) and join a HealthChoice Illinois MLTSS health plan.

If you don't pick a HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) health plan, you will be assigned to a different company's HealthChoice Illinois (MLTSS) health plan. Humana Gold Plus Integrated (Medicare-Medicaid Plan) does not have a HealthChoice Illinois MLTSS health plan.

After you are enrolled in a HealthChoice Illinois MLTSS health plan, you will have 90 days to switch to another HealthChoice Illinois MLTSS health plan.

You will get a new Member ID Card, a new *Member Handbook*, and a new *Provider Directory* from your HealthChoice Illinois MLTSS health plan.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Humana Gold Plus Integrated (Medicare-Medicaid Plan), it may take time before your membership ends and your new Medicare and Medicaid coverage begins. See page 165 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. Other situations when your membership ends

These are the cases when Humana Gold Plus Integrated (Medicare-Medicaid Plan) must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- 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 to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to prison.
- 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.

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 & 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 have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

- 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. Rules against asking you to leave our plan for any health related reason

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, 7 days a week. You should also call the Illinois Department of Healthcare and Family Services Health Benefits Hotline at 1-800-226-0768 8 a.m. to 4:30 p.m., Monday through Friday. TTY users should call 1-877-204-1012.

H. Your 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 make file a grievance or make a complaint about our decision to end your membership. You can also see Chapter 9, Section J, page 158 for information about how to make a complaint.

I. How to 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 at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Humana Gold Plus Integrated (Medicare-Medicaid Plan). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 and Medicaid must obey the laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, or sex.

If you want more information or 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 users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

If you have a disability and need help accessing health care services or a provider, call Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

C. Notice about Humana Gold Plus Integrated (Medicare-Medicaid Plan) 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.

Humana Gold Plus Integrated (Medicare-Medicaid Plan) has the right and the responsibility to collect payment for covered services when someone else has to pay first.

C1. Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s right of subrogation

Subrogation is the process by which Humana Gold Plus Integrated (Medicare-Medicaid Plan) gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit Humana.com.

If an insurer other than Humana Gold Plus Integrated (Medicare-Medicaid Plan) should pay for services related to an illness or injury, Humana Gold Plus Integrated (Medicare-Medicaid Plan) has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by Humana Gold Plus Integrated (Medicare-Medicaid Plan) will be secondary when another plan, including another insurance plan, provides you with coverage for health care services.

C2. Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s right of reimbursement

If you get money from a lawsuit or settlement for an illness or injury, Humana Gold Plus Integrated (Medicare-Medicaid Plan) has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

C3. Your responsibilities

As a member of Humana Gold Plus Integrated (Medicare-Medicaid Plan), you agree to:

- Let us know of any events that may affect Humana Gold Plus Integrated (Medicare-Medicaid Plan)'s rights of Subrogation or Reimbursement.
- Cooperate with Humana Gold Plus Integrated (Medicare-Medicaid Plan) when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help Humana Gold Plus Integrated (Medicare-Medicaid Plan) with its rights to Subrogation and Reimbursement.
- Authorize Humana Gold Plus Integrated (Medicare-Medicaid Plan) to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.
- Pay all such amounts to Humana Gold Plus Integrated (Medicare-Medicaid Plan) recovered by lawsuit, settlement or otherwise from any third person or his or her insurer to the extent of the benefits provided under the coverage, up to the value of the benefits provided.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Patient confidentiality and notice about privacy practices

We will ensure that all information, records, data and data elements related to you, used by our organization, employees, subcontractors and business associates, shall be protected from unauthorized disclosure pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR Part 431, Subpart F; and 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

carefully. If you have any questions, call Customer Care at 1-800-787-3311 (TTY:711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central 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. The call is free. Visit **Humana.com** for 24 hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

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



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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



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- 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



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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 (TTY: 711) at any time. The call is free.
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **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 (TTY: 711), 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.



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DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
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 Behavioral Health
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.



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For more information, visit **Humana.com**.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Care.

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.

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 D, page 125 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. We do not allow providers to "balance bill" you. Because Humana Gold Plus Integrated (Medicare-Medicaid Plan) pays the entire cost for your services, you should not get any bills from providers. Call Customer Care if you get any bills that you do not understand.

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 coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan developed by you and your care coordinator that describes what medical, behavioral health, social and functional needs you have and identifies goals and services to address those needs.

Care team: A care team, led by a care coordinator, may include doctors, nurses, counselors, or other professionals who are there to help you build a care plan and ensure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 20 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."



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

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.

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 D, page 125 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.

Cultural Competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

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 12 for information about how to contact Customer Care.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of 4 tiers.

Durable medical equipment (DME): Certain items your doctor orders for you to use at home. Examples are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child's physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

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."



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit [Humana.com](https://www.humana.com).

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 coordinators 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 an enrollee'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 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 (Medicare-Medicaid Plan) must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Humana Gold Plus Integrated (Medicare-Medicaid Plan) Member ID Card when you get any services or prescriptions. Call Customer Care if you get any bills you do not understand.

Because Humana Gold Plus Integrated (Medicare-Medicaid Plan) pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

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.

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 include Long Term Care and Home and Community Based Service (HCBS) waivers. HCBS waivers can offer services that will help you stay in your home and community.



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For more information, visit **Humana.com**.

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 21 for information about how to contact Medicaid in your state.

Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.

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 Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans”, that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

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 (Medicare-Medicaid Plan) 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.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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 works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

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 D, page 125 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).



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

- 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 30 explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

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.”

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. See Humana Gold Plus Integrated (Medicare-Medicaid Plan)’s Notice of Privacy Practices for more information about how Humana Gold Plus Integrated (Medicare-Medicaid Plan) protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

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 30 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. Humana Gold Plus Integrated (Medicare-Medicaid Plan) may not cover the service or drug if you don't get approval. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, Section C, 47.

Some drugs are covered only if you get prior authorization from our plan.

- Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.
For more information, visit **Humana.com**.

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.

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 have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can see someone that is not your PCP. If you don't get approval, Humana Gold Plus Integrated (Medicare-Medicaid Plan) may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. See Chapter 4, Section C, page 44 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. Only people who live in our service area can get Humana Gold Plus Integrated (Medicare-Medicaid Plan).

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 Medicaid agency: The Illinois Department of Healthcare and Family Services.

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.

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.



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Discrimination is Against the Law

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

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at 1-800-787-3311 (TTY 711).

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

Discrimination Grievances

P.O. Box 14618

Lexington, KY 40512 – 4618

1-800-787-3311, or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-800-787-3311 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-787-3311 (TTY: 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-787-3311 (TTY: 711)**.

繁體中文 (Chinese): 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 **1-800-787-3311 (TTY: 711)**。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-787-3311 (TTY: 711)** 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-787-3311 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-787-3311 (телетайп: 711)**.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-787-3311 (TTY: 711)**.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-787-3311 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-787-3311 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-787-3311 (ATS : 711)**.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-787-3311 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-787-3311 (TTY: 711)**.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kójj' hódíílnih **1-800-787-3311 (TTY: 711)**.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-787-3311 (رقم هاتف الصم والبك: 711)**.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-787-3311 (TTY: 711)** पर कॉल करें।

وُڊُرَا (Urdu):

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-800-787-3311 (TTY: 711)**۔

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If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information,** visit **Humana.com**.

Humana Gold Plus Integrated Customer Care

CALL	<p>1-800-787-3311</p> <p>Monday - Friday, from 8 a.m. - 8 p.m. Central time.</p> <p>Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>(TTY: 711)</p> <p>Calls to this number are free.</p> <p>Monday - Friday, from 8 a.m. - 8 p.m. Central time.</p>
WRITE	<p>Humana Gold Plus Integrated (Medicare-Medicaid Plan)</p> <p>P.O. Box 14168 Lexington, KY 40512-4168</p>
WEBSITE	<p>Humana.com</p>



If you have questions, please call Humana Gold Plus Integrated (Medicare-Medicaid Plan) at 1-800-787-3311 (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. Central time. The call is free. **For more information**, visit **Humana.com**.