



Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Humana Group Medicare Advantage PPO Plan

This booklet gives you the details about your Medicare health care coverage for this plan year. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Humana Group Medicare Advantage PPO Plan, is offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Insurance of Puerto Rico, Inc., and Humana Benefit Plan of Illinois, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Insurance of Puerto Rico, Inc., and Humana Benefit Plan of Illinois, Inc. When it says "plan" or "our plan," it means Humana Group Medicare Advantage PPO Plan.)

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call Customer Care (*phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet*) or see your Evidence of Coverage for more information, including cost-sharing that applies to out-of-network services.

This document is available for free in Spanish.

This information is available in a different format, including Braille, large print, and audio. Please call Customer Care (*phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet*) if you need plan information in another format.

Benefits, premiums and/or member copayments/coinsurance may change on the beginning of each plan year. The provider network may change at any time. You will receive notice when necessary.

2022 Evidence of Coverage

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Chapter 2. Important phone numbers and resources

Tells you how to get in touch with our plan and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your medical services

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Gives the details about which types of medical care are covered and not covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.

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Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.

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Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

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SECTION 1 Introduction

Section 1.1 You are enrolled in Humana Group Medicare Advantage PPO Plan, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Humana Group Medicare Advantage PPO Plan.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and 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

There are different types of Medicare health plans. Humana Group Medicare Advantage PPO Plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Humana Group Medicare Advantage PPO Plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Humana Group Medicare Advantage PPO Plan.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Humana Group Medicare Advantage PPO Plan covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Humana Group Medicare Advantage PPO Plan coverage between January 1, 2022 and December 31, 2022.

Chapter 1. Getting started as a member

Each year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the Humana Group Medicare Advantage PPO Plan after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Humana Group Medicare Advantage PPO Plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B);
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area);
- -- *and* -- You are a United States citizen or are lawfully present in the United States.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies.)
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Humana Group Medicare Advantage PPO Plan

Although Medicare is a Federal program, Humana Group Medicare Advantage PPO Plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area.

The service area is described below:

Where is Humana Group Medicare Advantage PPO Plan available?

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

The employer, union or trust determines where they are going to offer the plan.

If you plan to move out of the service area, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

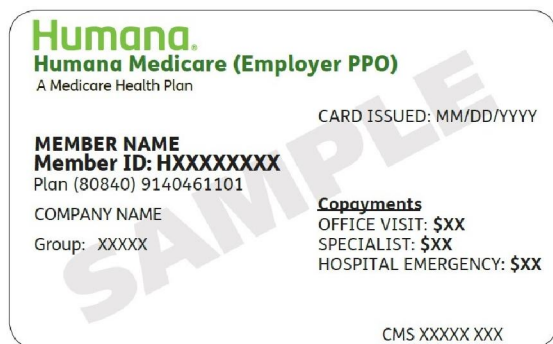
Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Humana Group Medicare Advantage PPO Plan if you are not eligible to remain a member on this basis. Humana Group Medicare Advantage PPO Plan must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Humana Group Medicare Advantage PPO Plan membership card, you may have to pay the full cost of the services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Humana Group Medicare Advantage PPO Plan membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Section 3.2 The Provider Directory: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network providers or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You may ask Customer Care for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.humana.com or 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.

Chapter 1. Getting started as a member

**SECTION 4 Your monthly premium for Humana Group Medicare
Advantage PPO Plan**

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with your former employer or union. Please contact your former employer or union's benefits administrator for information about your plan premium.

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Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of the *Medicare & You 2022* handbook gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2022* handbook from the Medicare website www.medicare.gov or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

For questions regarding premium payment, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You must make your request no later than 60 days after the date your membership ends.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in your *Annual Notice of Change*.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information about you, including your address and telephone number. It shows your specific plan coverage.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 Humana Group Medicare Advantage PPO Plan contacts

(how to contact us, including how to reach Customer Care at the plan)

SECTION 2 Medicare

(how to get help and information directly from the Federal Medicare program)

SECTION 3 State Health Insurance Assistance Program

(free help, information, and answers to your questions about Medicare)

SECTION 4 Quality Improvement Organization

(paid by Medicare to check on the quality of care for people with Medicare)

SECTION 5 Social Security

SECTION 6 Medicaid

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

SECTION 7 How to contact the Railroad Retirement Board

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

SECTION 1 Humana Group Medicare Advantage PPO Plan contacts
(how to contact us, including how to reach Customer Care at the plan)

How to contact our plan's Customer Care

For assistance with claims, billing or member card questions, please call or write to the Humana Group Medicare Advantage PPO Plan Customer Care. We will be happy to help you.

Method	Customer Care - Contact Information
CALL	Customer Care at (800) 733-9064. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	<u>www.humana.com</u>

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions For Medical Care - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited coverage decisions only
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals For Medical Care - Contact Information
CALL	<p>Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. For expedited appeals please call 1-800-867-6601.</p> <p>Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p>
FAX	<p>1-800-949-2961 for expedited appeals only.</p>
WRITE	<p>Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165</p>

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints About Medical Care - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. For expedited appeals please call 1-800-867-6601. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited grievances only
WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165
MEDICARE WEBSITE	You can submit a complaint about your Humana Group Medicare Advantage PPO Plan directly to Medicare. To submit an online complaint to Medicare, go to <u>www.medicare.gov/MedicareComplaintForm/home.aspx</u> .

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests - Contact Information
CALL	<p>Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays.</p> <p>Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p>
WRITE	<p>Humana P.O. Box 14168 Lexington, KY 40512-4168</p>

Chapter 2. Important phone numbers and resources

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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 (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare - Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare (continued) - Contact Information
WEBSITE	<p data-bbox="483 281 743 315"><u>www.medicare.gov</u></p> <p data-bbox="483 317 1425 533">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="483 569 1425 644">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="483 680 1425 938" style="list-style-type: none"> <li data-bbox="483 680 1425 749">● Medicare Eligibility Tool: Provides Medicare eligibility status information. <li data-bbox="483 751 1425 938">● Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="483 974 1425 1043">You can also use the website to tell Medicare about any complaints you have about Humana Group Medicare Advantage PPO Plan:</p> <ul data-bbox="483 1079 1425 1302" style="list-style-type: none"> <li data-bbox="483 1079 1425 1302">● Tell Medicare about your complaint: You can submit a complaint about Humana Group Medicare Advantage PPO Plan directly to Medicare. To submit a complaint to Medicare, go to <u>www.medicare.gov/MedicareComplaintForm/home.aspx</u>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p data-bbox="483 1337 1425 1554">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 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. (You can 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> <ul data-bbox="483 1589 1425 1885" style="list-style-type: none"> <li data-bbox="483 1589 1425 1885">● Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <u>www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision</u> for more information on the individual requirement for MEC.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

The State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program (SHIP) counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
 - Option #1: You can have a **live chat**
 - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
 - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this booklet.

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state.

The Quality Improvement Organization (QIO) has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization (QIO) is an independent organization. It is not connected with our plan.

You should contact your Quality Improvement Organization (QIO) in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Contact information for your state Quality Improvement Organization (QIO) can be found in "Exhibit A" in the back of this booklet.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security - Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	<u>www.ssa.gov/</u>

SECTION 6 Medicaid

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid office.

Contact information for your state Medicaid Office can be found in "Exhibit A" in the back of this booklet.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board - Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	<u>rrb.gov</u>

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are located in Section 1 of this chapter.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

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SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Humana Group Medicare Advantage PPO Plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Humana Group Medicare Advantage PPO Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart.** (This chart is in Chapter 4 of this booklet.)
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Chapter 3. Using the plan's coverage for your medical services

- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider. (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider Directory*.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services 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 conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

We list the providers that participate with our plan in our *Provider Directory*. While you are a member of our plan you may use either network providers or out-of-network providers. However, your out-of-pocket costs may be higher if you use out-of-network providers. See Chapter 4 (*Medical Benefits Chart, What is covered and what you pay*) for more information on what your costs will be.

You don't need to get a referral for covered services. Some services require prior authorization from providers. However, before getting services from out-of-network providers, you may want to confirm with us that the services you are getting are covered by us and are medically necessary. See Chapter 4 Section 2 for information about which services require prior authorization. If an out-of-network provider sends you a bill that you think we should pay, refer to Chapter 5 (*Asking the plan to pay its share of a bill you have received for covered services*) for information on how to ask us to pay that bill for you. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay.

Chapter 3. Using the plan's coverage for your medical services

You won't have to pay an out-of-network provider any more than what he or she would have gotten if you had been covered with the Original Medicare Plan. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous 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 your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Contact Customer Care at the telephone number listed in Chapter 2, Section 1 for assistance with selecting a new qualified provider to continue managing your health care needs.

Section 2.2 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

Chapter 3. Using the plan's coverage for your medical services

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "**medical emergency**" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help 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 our plan has been told 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. Call the phone number located in Chapter 2, Section 1 of this booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

You are covered for emergency care worldwide. See Chapter 4 (*Medical Benefits Chart, What is covered and what you pay*) for more information.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you may pay a higher share of the costs for your care.

Chapter 3. Using the plan's coverage for your medical services

The plan's *Provider Directory* will tell you which urgent care facilities in your area are in our plan's network. This information can also be found online at www.humana.com. For any other questions regarding urgently needed care, please contact Customer Care at the number located in Chapter 2, Section 1 of this booklet.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Our plan covers urgently needed services if you receive the care outside of the United States. See Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) for more information. If you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. You can send the bill to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.humana.com/alert for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Humana Group Medicare Advantage PPO Plan covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

Chapter 3. Using the plan's coverage for your medical services

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Care to get more information. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward your out-of-pocket maximum.

You can call Customer Care when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Chapter 3. Using the plan's coverage for your medical services

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Care to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs **\$100** as part of the research study. Let's also say that your share of the costs for this test is **\$20** under Original Medicare, but the test would be **\$10** under our plan's benefits. In this case, Original Medicare would pay **\$80** for the test and we would pay another **\$10**. This means that you would pay **\$10**, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.

Chapter 3. Using the plan's coverage for your medical services

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies". (The publication is available at:

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.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for 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.

Section 6.2 Receiving 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 conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *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 you receive is limited to *non-religious* aspects of care.

Chapter 3. Using the plan's coverage for your medical services

- If you get services from this institution that are provided to you in a facility, the following condition applies:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

You are covered for an unlimited number of medically necessary inpatient hospital days. See Chapter 4 (*Medical Benefits Chart, What is covered and what you pay*).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Humana Group Medicare Advantage PPO Plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Care to find out about the requirements you must meet and the documentation you need to provide. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Humana Group Medicare Advantage PPO Plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Humana Group Medicare Advantage PPO Plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost-sharing? Will it change after 36 months?

Your cost-sharing for Medicare oxygen equipment coverage may vary depending on place of treatment. (See Chapter 4 *Medical Benefits Chart*, *Durable Medical Equipment* benefit, for more information on what your cost will be.)

Your cost-sharing will not change after being enrolled for 36 months in Humana Group Medicare Advantage PPO Plan.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Humana Group Medicare Advantage PPO Plan, join Humana Group Medicare Advantage PPO Plan for 12 months, and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in Humana Group Medicare Advantage PPO Plan and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

Section 1.2 What is your plan deductible?

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Section 1.4 Our plan does not allow providers to "balance bill" you

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Humana Group Medicare Advantage PPO Plan. Later in this chapter, you can find information about medical services that are not covered.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The "**deductible**" is the amount you must pay for medical services before our plan begins to pay its share.
- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Care.

Section 1.2 What is your plan deductible?

You pay nothing for your combined annual deductible.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is \$1000.00. This is the most you pay during the plan year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below) If you have paid \$1000.00 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the plan year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is \$1000.00. This is the most you pay during the plan year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below.) If you have paid \$1000.00 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the plan year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to "balance bill" you

As a member of Humana Group Medicare Advantage PPO Plan, an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balanced billed" you, call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Humana Group Medicare Advantage PPO Plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:


- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from PPO.
 - Covered services that need approval in advance to be covered as in-network services are marked in the bulleted section of the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
 - The preauthorization list can be found here: www.humana.com/PAL
 - You may not need approval in advance for out-of-network services from out-of-network providers.
 - While you may not need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:


- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* handbook. View it online at www.medicare.gov or ask for a copy 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you when services are received from a network provider. You may pay more if services are received from a non-network provider. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart


Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound 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.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>


Services that are covered for you	What you must pay when you get these services
<p>Acupuncture (Medicare-covered) for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 20 combined In & Out of Network visits per year for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. <p>Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.</p>	
	<u>In Network</u>
Up to 20 combined In & Out of Network visits per year for Medicare beneficiaries under the following circumstances:	\$0 copayment for each specialist's office visit
For the purpose of this benefit, chronic low back pain is defined as:	<u>Out of Network</u>
<ul style="list-style-type: none"> • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. 	\$0 copayment for each specialist's office visit


Services that are covered for you	What you must pay when you get these services
Advanced imaging	
Covered services include, but are not limited to:	<u>In Network</u>
<ul style="list-style-type: none"> • CT scans • MRI • MRA • Prior authorization may be required. Contact the plan for details. 	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each freestanding radiological facility visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each freestanding radiological facility visit
	\$0 copayment for each outpatient hospital visit


Services that are covered for you	What you must pay when you get these services
Allergy shots and serum	
Administration and serum related to medically necessary allergy shots.	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p>



Services that are covered for you	What you must pay when you get these services
Ambulance services <ul style="list-style-type: none"> <p>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.</p> <p>Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p> 	
	<p><u>Emergency In Network</u></p> <p>\$0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p>
	<p><u>Emergency Out of Network</u></p> <p>\$0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p>
	<p><u>Non-Emergency In Network</u></p> <p>\$0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p>
	<p><u>Non-Emergency Out of Network</u></p> <p>\$0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p>

Services that are covered for you	What you must pay when you get these services
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p>


Services that are covered for you	What you must pay when you get these services
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
 Breast cancer screening (mammograms)	
Covered services include:	<u>In Network</u>
<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 copayment for each primary care physician's office visit \$0 copayment for each specialist's office visit \$0 copayment for each freestanding radiological facility visit \$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit \$0 copayment for each specialist's office visit \$0 copayment for each freestanding radiological facility visit \$0 copayment for each outpatient hospital visit



Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services	
<ul style="list-style-type: none"> Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. 	<u>In Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each outpatient hospital visit
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	
<p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<u>In Network</u>
	\$0 copayment for each primary care physician's office visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit

Services that are covered for you	What you must pay when you get these services
 Cardiovascular disease testing	
<p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), covered once every 5 years (60 months).</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p>
 Cervical and vaginal cancer screening	
<p>Covered services include:</p> <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p>

Services that are covered for you	What you must pay when you get these services
Chemotherapy drugs	
Medically-necessary chemotherapy services and treatments.	<u>In Network</u>
<ul style="list-style-type: none"> Prior authorization may be required. Contact the plan for details. 	<p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>
	<u>Out of Network</u>
	<p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>
Chiropractic services (Medicare-covered)	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation 	<p>\$0 copayment for each specialist's office visit</p>
	<u>Out of Network</u>
	<p>\$0 copayment for each specialist's office visit</p>


Services that are covered for you	What you must pay when you get these services
 Colorectal cancer screening	
For people 50 and older, the following are covered:	<u>In Network</u>
<ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months 	\$0 copayment for each primary care physician's office visit
One of the following every 12 months:	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> Guaiac-based fecal occult blood test (gFOBT) Fecal immunochemical test (FIT) 	\$0 copayment for each ambulatory surgical center visit
DNA based colorectal screening every 3 years	\$0 copayment for each outpatient hospital visit
For people at high risk of colorectal cancer, we cover:	
<ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months 	<u>Out of Network</u>
For people not at high risk of colorectal cancer, we cover:	\$0 copayment for each primary care physician's office visit
<ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	\$0 copayment for each specialist's office visit
	\$0 copayment for each ambulatory surgical center visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
COVID-19 Diagnosis, Treatment & Vaccine	
Covered services include:	<u>In Network</u>
Medicare-covered Antibody and Diagnostic Testing:	\$0 copayment
<ul style="list-style-type: none"> Testing is covered when medically necessary and ordered by a physician. Coverage amount is not to exceed the Humana contracted rate or Medicare allowable charges. 	Benefit does not apply to your combined maximum out-of-pocket
	<u>Out of Network</u>
Treatment for confirmed COVID-19 Diagnosis:	\$0 copayment
<ul style="list-style-type: none"> Hospitalization, medical services Home delivered meals - 14 days (28 meals) Vaccine for COVID-19 	Benefit does not apply to your combined maximum out-of-pocket
Prior authorization rules may apply. Contact plan for details.	
Dental services (Medicare-covered)	
In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:	<u>In Network</u>
	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> Surgery of the jaw or related structures Setting fractures of the jaw or facial bones Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease Services that would be covered when provided by a doctor 	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p>
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Diabetes self-monitoring supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. <ul style="list-style-type: none"> These are the only covered brands of blood glucose monitors and test strips: ACCU-CHEK® manufactured by Roche, or Trividia products sometimes packaged under your pharmacy's name. Humana covers any blood glucose monitors and test strips specified within the preferred brand list above. In general, alternate non-preferred brand products are not covered unless your doctor provides adequate information that the use of an alternate brand is medically necessary in your specific situation. If you are new to Humana and are using a brand of blood glucose monitor and test strips that are not on the preferred brand list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate non-preferred brand. During this time, you should talk with your doctor to decide whether any of the preferred product brands listed above are medically appropriate for you. Non-preferred brand products will not be covered following the initial 90 days of coverage without an approved prior authorization for a coverage exception. For Continuous Glucose Monitors, see Durable medical equipment (DME) and related supplies. 	
	<p><u>In Network</u></p> <p>\$0 copayment from a durable medical equipment provider</p> <p>\$0 copayment from a pharmacy</p> <p><u>Out of Network</u></p> <p>\$0 copayment from a durable medical equipment provider</p> <p>\$0 copayment from a pharmacy</p>

Services that are covered for you	What you must pay when you get these services
Diabetes self-monitoring supplies (continued)	
<ul style="list-style-type: none">For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	


Services that are covered for you	What you must pay when you get these services
 Diabetes self-management training	
<p>For all people who have diabetes (insulin and non-insulin users) covered services include:</p> <ul style="list-style-type: none"> Diabetes self-management training is covered under certain conditions 	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>
Diabetic Eye Exam	
<p>For people with diabetes, screening for diabetic retinopathy is covered once per year.</p> <p>Contact the plan for details.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p>

Services that are covered for you	What you must pay when you get these services
Diagnostic Colonoscopy	
Colonoscopy services performed due to past or present history (such as gastrointestinal symptoms or disease, polyps, or cancer) or physical symptoms such as rectal bleeding or pain.	<u>In Network</u>
	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> Prior authorization may be required. Contact the plan for details. 	\$0 copayment for each ambulatory surgical center visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each ambulatory surgical center visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies	
(For a definition of "durable medical equipment," see Chapter 10 of this booklet.)	<u>In Network</u>
Covered items include, but are not limited to:	0% coinsurance at a durable medical equipment provider
<ul style="list-style-type: none"> ● 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 ● Nebulizers ● Walkers ● Continuous Glucose Monitors* ● We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. ● The most recent list of suppliers is available on our website at www.humana.com ● Prior authorization may be required. Contact the plan for details. 	0% coinsurance at a pharmacy Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)
	<u>Out of Network</u>
	0% coinsurance at a durable medical equipment provider 0% coinsurance at a pharmacy Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)
*Continuous Glucose Monitors available only through durable medical equipment provider. Contact the plan for more details.	

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>You are covered for emergency care worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit to Humana for reimbursement, for more information please see Chapter 5. We may not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.</p>	
	<u>In Network</u>
<ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 	\$0 copayment for emergency services in an emergency room
	<u>Out of Network</u>
<p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p>	\$0 copayment for emergency services in an emergency room
<p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p>	<p>Worldwide Coverage: 20% coinsurance for emergency services outside of the U.S. and its territories after a \$100 deductible. Benefit is limited to \$50,000 each plan year or 60 consecutive days, whichever is reached first. Benefit does not apply to your combined annual out-of-pocket maximum.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)


Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	<p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>
<p> Glaucoma screening</p> <p>For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: 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>	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Health and wellness education programs</p> <p>Additional Telehealth Services</p> <p>Use a phone, computer, tablet or other video technology for diagnosis and treatment of certain non-emergency medical care when your regular healthcare provider is not available. While this benefit is not intended to replace your regular healthcare provider, a virtual visit can sometimes be another option when your regular healthcare provider's office is not available or open. You are not required to use this benefit, and you can contact your regular healthcare provider's office to request an appointment. When you have an emergency, such as a life-threatening injury, illness or major trauma, call 911 or go to your nearest emergency room. Humana is not responsible for the availability or ongoing participation of any provider. Provider availability may change. Always make sure your provider is in the network before you receive care. If you want the name of the provider or need a provider directory you may access www.humana.com/finder/provider-directories/ or call Customer Care.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Primary care physician services • Specialist services • Behavioral health and substance abuse services • Urgently needed care <p><u>You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service via telehealth.</u></p>	
	<p>\$0 copayment for each primary care physician - virtual visit</p> <p>\$0 copayment for each specialist - virtual visit</p> <p>\$0 copayment for each behavioral health and substance abuse - virtual visit</p> <p>\$0 copayment for each urgent care - virtual visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Humana Health Coaching</p> <p>Work toward wellness with Humana Health Coaching</p> <ul style="list-style-type: none"> ● Develop a personalized action plan with a coach to set goals for a healthier lifestyle ● Experience unlimited and ongoing (year-round) one-on-one interactions with a coach to reinforce healthy changes ● Get support and guidance from a professional to help you achieve your health and wellness goals <p>Contact Humana Health Coaching at 1-877-567-6450 (TTY: 711) Monday - Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>Humana Health Coaching is available in all states.</p>
<p>Post-Discharge Personal Home Care</p> <p>With the Personal Home Care benefit you will be eligible to receive services for a minimum of 3 hours per day up to a maximum of 6 hours per discharge from an inpatient hospitalization or skilled nursing facility stay. PHC includes certain in-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, and preparing meals). Personal home care services must be initiated within 30 days of discharge event and utilized within 60 days of discharge.</p> <p>Prior authorization rules may apply. Contact the plan for details.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>Personal Home Care is available in all states except Hawaii</p>

Services that are covered for you	What you must pay when you get these services
<p>Post-Discharge Transportation</p> <p>You are covered for 12 one-way trip(s) to plan-approved locations per facility discharge by car, van, or wheelchair access vehicle. There is a maximum allowed travel distance of 50 miles per trip. Benefit must be utilized within 60 days of discharge event.</p> <p>Benefit is subject to transportation provider availability within the plan service area. Please contact Customer Care for information on how to arrange transportation. Customer Care will confirm your benefits and guide you to the transportation provider to plan your trip.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>Post-Discharge Transportation is available in all states except Hawaii</p>
<p>SilverSneakers® Fitness</p> <p>This fitness program includes access to thousands of participating locations and signature group exercise classes led by certified instructors. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. Go to www.SilverSneakers.com to learn more about your benefit.</p> <p>Any fitness center services that usually have an extra fee are not included in your membership.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>SilverSneakers® Fitness is available in all states.</p>
<p>Smoking Cessation Program</p> <p>Stop smoking with help from a health coach. The Humana Health Coaching comprehensive tobacco cessation program includes: unlimited one-on-one coaching and access to resources. For eligible members, services also include a 3 month's supply of nicotine replacement therapy products. Contact Humana Health Coaching at 1-877-567-6450 (TTY: 711) Monday - Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>Available in all states.</p>

Services that are covered for you	What you must pay when you get these services
Post-Discharge Well Dine Meal Program	
<p>After your inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 14 days, at no cost to you. 28 nutritious meals will be delivered to your home. These meals can be ordered by your care manager or may be ordered directly from the meal order vendor. The request must be completed within 30 days of your inpatient stay.</p> <p>For more information, call the number on the back of your Humana member ID card for further details or to take advantage of this benefit after your discharge.</p>	<p>\$0 copayment</p> <p>Benefit does not apply to your combined maximum out-of-pocket</p> <p>Well Dine Meal Program is available in all states.</p>
Hearing services (Medicare-covered)	
<p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p>
	<p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p>


Services that are covered for you	What you must pay when you get these services
 HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: <ul style="list-style-type: none"> ● One screening exam every 12 months For women who are pregnant, we cover: <ul style="list-style-type: none"> ● Up to three screening exams during a pregnancy 	<u>In Network</u> \$0 copayment for each primary care physician's office visit \$0 copayment for each specialist's office visit <u>Out of Network</u> \$0 copayment for each primary care physician's office visit \$0 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</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 ● Prior authorization may be required for home health services. Contact the plan for details. 	<p><u>In Network</u></p> <p>\$0 copayment for each home health visit</p> <p>Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each home health visit</p> <p>Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)</p>

Services that are covered for you	What you must pay when you get these services
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with the plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	<p><u>In Network – Medical Supplies</u></p> <p>0% coinsurance at a medical supply provider</p> <p>0% coinsurance at a pharmacy</p> <p><u>In Network - Medicare Part B Covered Drugs</u></p> <p>0% coinsurance for Medicare Part B drugs at a pharmacy</p> <p>\$0 copayment for administration of drugs at a primary care physician's office</p> <p>\$0 copayment for administration of drugs at a specialist's office</p> <p><u>In Network - Physician/Practitioner services, including doctor's office visits</u></p> <p>\$0 copayment for each primary care physician's office visit</p>

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (continued)	<p><u>Out of Network – Medical Supplies</u></p> <p>0% coinsurance at a medical supply provider</p> <p>0% coinsurance at a pharmacy</p> <p><u>Out of Network – Medicare Part B Covered Drugs</u></p> <p>0% coinsurance for Medicare Part B drugs at a pharmacy</p> <p>\$0 copayment for administration of drugs at a primary care physician's office</p> <p>\$0 copayment for administration of drugs at a specialist's office</p> <p><u>Out of Network – Physician/Practitioner services, including doctor's office visits</u></p> <p>\$0 copayment for each primary care physician's office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u></p> <ul style="list-style-type: none"> • Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the consultation services that Original Medicare pays for. <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Humana Group Medicare Advantage PPO Plan.</p>

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) <u>For services that are covered by Humana Group Medicare Advantage PPO Plan but are not covered by Medicare Part A or B: Humana Group Medicare Advantage PPO Plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</u>	
 Immunizations	
Covered Medicare Part B services include:	<u>In Network</u>
<ul style="list-style-type: none"> ● Pneumonia vaccine 	\$0 copayment for each primary care physician's office visit
<ul style="list-style-type: none"> ● Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary 	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> ● Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B 	<u>Out of Network</u>
<ul style="list-style-type: none"> ● COVID-19 Vaccine 	\$0 copayment for each primary care physician's office visit
<ul style="list-style-type: none"> ● Other vaccines if you are at risk and meet Medicare Part B coverage rules 	\$0 copayment for each specialist's office visit
We also cover some vaccines under our outpatient prescription drug benefit.	


Services that are covered for you	What you must pay when you get these services
Inpatient hospital care	
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.
You are covered for unlimited number of days for medically necessary services.	
Covered services include, but are not limited to:	<u>In Network</u>
<ul style="list-style-type: none"> • Semi-private room (or a private room if 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 • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational and speech language therapy • Inpatient substance abuse services 	\$0 copayment per admission \$0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)
	<u>Out of Network</u>
	\$0 copayment per admission \$0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> ● Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Humana Group Medicare Advantage PPO Plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. ● Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need ● Physician services ● Prior authorization is required for inpatient hospital care ● Prior authorization is required for transplant services All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 711) Monday-Friday 8:30 am-5 pm EST. 	


Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare-Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	


Services that are covered for you	What you must pay when you get these services
Inpatient mental health care <ul style="list-style-type: none"> • Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital. <ul style="list-style-type: none"> • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan. • Prior authorization is required for inpatient mental health care. 	
<p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p> <p><u>In Network</u></p> <p>\$0 copayment per admission in an inpatient hospital</p> <p>\$0 copayment per admission in an inpatient psychiatric hospital</p> <p>\$0 copayment for physician services at an inpatient psychiatric hospital</p> <p>Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)</p> <p><u>Out of Network</u></p> <p>\$0 copayment per admission in an inpatient hospital</p> <p>\$0 copayment per admission in an inpatient psychiatric hospital</p> <p>\$0 copayment for physician services at an inpatient psychiatric hospital</p> <p>Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)</p>	

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay	
<p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician 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 to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p><u>In Network</u></p> <p>You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered.</p> <p>\$0 copayment for physician services at an inpatient psychiatric hospital</p> <p>\$0 copayment for physician services at a skilled nursing facility</p> <p><u>Out of Network</u></p> <p>You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered.</p> <p>\$0 copayment for physician services at an inpatient psychiatric hospital</p> <p>\$0 copayment for physician services at a skilled nursing facility</p>

Services that are covered for you	What you must pay when you get these services
<p> Kidney disease education services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> ● Kidney disease education services to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. 	
	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>


Services that are covered for you	What you must pay when you get these services
Laboratory services	
Covered services include, but are not limited to:	<u>In Network</u>
<ul style="list-style-type: none"> • Blood tests • Tissue specimen tests • Screening tests • Urinalysis • Prior authorization may be required. Contact the plan for details. 	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each freestanding laboratory visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each freestanding laboratory visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
 Medical nutrition therapy	
<p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
Medical supplies	
Coverage for certain non-durable health care materials ordered by a provider.	<u>In Network</u>
Covered items include, but are not limited to:	0% coinsurance at a medical supply provider
<ul style="list-style-type: none"> • Catheters • Cotton swabs • IV set-ups and supplies • Surgical supplies including bandages and dressings • General supplies 	0% coinsurance at a pharmacy
	<u>Out of Network</u>
	0% coinsurance at a medical supply provider
	0% coinsurance at a pharmacy
 Medicare Diabetes Prevention Program (MDPP)	
MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.	<u>In Network</u>
	\$0 copayment
MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	<u>Out of Network</u>
	\$0 copayment

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical 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 • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • 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^(R), Procrit^(R), Epoetin Alfa, Aranesp^(R), or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Prior authorization may be required for Part B drugs. You may also have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." Contact the plan for details. 	
<p><u>In Network</u></p> <p>0% coinsurance for Medicare Part B drugs at a pharmacy</p> <p>\$0 copayment for administration of drugs at a primary care physician's office</p> <p>\$0 copayment for administration of drugs at a specialist's office</p>	
<p><u>Out of Network</u></p> <p>0% coinsurance for Medicare Part B drugs at a pharmacy</p> <p>\$0 copayment for administration of drugs at a primary care physician's office</p> <p>\$0 copayment for administration of drugs at a specialist's office</p>	

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs (continued)</p> <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: <u>www.humana.com/PAL</u></p>	
<p>Nuclear medicine</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • PET scans • NOPR • SPECT • Prior authorization may be required. Contact the plan for details. 	
<u>In Network</u>	
\$0 copayment for nuclear medicine at a freestanding radiological facility	
\$0 copayment for nuclear medicine at an outpatient hospital	
<u>Out of Network</u>	
\$0 copayment for nuclear medicine at a freestanding radiological facility	
\$0 copayment for nuclear medicine at an outpatient hospital	

Services that are covered for you	What you must pay when you get these services
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p>
Opioid treatment services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: <ul style="list-style-type: none"> ● U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. ● Dispensing and administration of MAT medications (if applicable) ● Substance use counseling ● Individual and group therapy ● Toxicology testing ● Intake activities ● Periodic assessments 	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
Outpatient Basic Radiological Services	
Covered services include, but are not limited to:	<u>In Network</u>
<ul style="list-style-type: none"> • Radiologic examination • X-rays • Prior authorization may be required. Contact the plan for details. 	<p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>
	<u>Out of Network</u>
	<p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>


Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests, therapeutic services and supplies	
Covered services include, but are not limited to:	<u>In Network</u>
● Radiologic examination	\$0 copayment for each primary care physician's office visit
● Other outpatient diagnostic tests	\$0 copayment for each specialist's office visit
● Interpretation of measurements	\$0 copayment for each urgent care center visit
● Prior authorization may be required. Contact the plan for details.	\$0 copayment for each freestanding radiological facility visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each freestanding radiological facility visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care	
Covered services include:	<u>In Network</u>
Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each outpatient hospital visit


Services that are covered for you	What you must pay when you get these services
Outpatient rehabilitation services	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> Physical therapy 	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> Occupational therapy 	\$0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit
<ul style="list-style-type: none"> Speech language therapy 	\$0 copayment for each outpatient hospital visit
<ul style="list-style-type: none"> Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs) 	
<ul style="list-style-type: none"> Prior authorization is required for physical, occupational, and speech therapies 	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services	
<p>You are covered for outpatient mental health services for treatment to prevent alcohol and drug abuse.</p> <ul style="list-style-type: none"> • Prior authorization may be required. Contact the plan for details. 	<u>In Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	\$0 copayment for each urgent care center visit
	\$0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."</p> <p>You can also find more information in a Medicare fact sheet called "Are you a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <ul style="list-style-type: none"> ● Prior authorization is required for abdominoplasty, balloon sinuplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient cardiac catheterizations, penile implant, rhinoplasty, obesity, oral surgeries, and surgery for obstructive sleep apnea 	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p> <p>\$0 copayment for each ambulatory surgical center visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p> <p>\$0 copayment for each ambulatory surgical center visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services	
<ul style="list-style-type: none"> "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization 	<p><u>In Network</u></p> <p>\$0 copayment for each partial hospitalization visit</p>
<ul style="list-style-type: none"> Prior authorization is required for partial hospitalization services 	<p><u>Out of Network</u></p> <p>\$0 copayment for each partial hospitalization visit</p>
 Physical exams (Routine)	
In addition to the Annual Wellness Visit or the "Welcome to Medicare" physical exam, you are covered for the following exam once per year:	<u>In Network</u>
<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 	<p>\$0 copayment for each primary care physician's office visit</p>
<ul style="list-style-type: none"> Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately. 	<p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p>


Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> Medically-necessary medical care furnished in a physician's office 	\$0 copayment for each primary care physician's office visit
<ul style="list-style-type: none"> Consultation, diagnosis, and treatment by a specialist 	\$0 copayment for each specialist's office visit
<ul style="list-style-type: none"> Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment 	<u>Out of Network</u>
<ul style="list-style-type: none"> Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare 	\$0 copayment for each primary care physician's office visit
<ul style="list-style-type: none"> Second opinion by another network provider prior to surgery 	\$0 copayment for each specialist's office visit


Services that are covered for you	What you must pay when you get these services
Podiatry services (Medicare-covered)	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) 	\$0 copayment for each specialist's office visit
	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit
 Prostate cancer screening exams	
For men 50 and older, covered services include the following once every 12 months:	<u>In Network</u>
<ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test 	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit
	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit
	\$0 copayment for each specialist's office visit


Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function.</p> <p>These include, but are not limited to:</p> <ul style="list-style-type: none"> ● Colostomy bags and supplies directly related to colostomy care ● Pacemakers ● Braces, prosthetic shoes, and artificial limbs ● Breast prostheses, including a surgical brassiere after a mastectomy ● Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices ● Also includes some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more details ● Prior authorization is required for prosthetic devices 	
	<p><u>In Network</u></p> <p>0% coinsurance from a prosthetics provider</p> <p>Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711)</p>
	<p><u>Out of Network</u></p> <p>0% coinsurance from a prosthetics provider</p> <p>Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711)</p>

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services	
Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	<u>In Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit
	\$0 copayment for each outpatient hospital visit
	<u>Out of Network</u>
	\$0 copayment for each specialist's office visit
	\$0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit
	\$0 copayment for each outpatient hospital visit


Services that are covered for you	What you must pay when you get these services
Radiation therapy	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> • Radiation (radium and isotope) therapy including technician materials and supplies • Prior authorization is required for radiation therapy 	<p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>
	<u>Out of Network</u>
	<p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
Renal (Kidney) dialysis	
Covered services include:	<u>In Network</u>
<ul style="list-style-type: none"> Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). 	\$0 copayment for each dialysis center visit
<ul style="list-style-type: none"> Inpatient dialysis treatments (if you are admitted to a hospital for special care). 	\$0 copayment for each outpatient hospital visit
<ul style="list-style-type: none"> Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). 	<u>Out of Network</u>
<ul style="list-style-type: none"> Home dialysis equipment and supplies. 	\$0 copayment for each dialysis center visit
<ul style="list-style-type: none"> Certain home support services (such as when medically necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). 	\$0 copayment for each outpatient hospital visit
<p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section "Medicare Part B prescription drugs."</p>	
 Screening and counseling to reduce alcohol misuse	
We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.	<u>In Network</u>
	\$0 copayment for each primary care physician's office visit
If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	<u>Out of Network</u>
	\$0 copayment for each primary care physician's office visit

Services that are covered for you	What you must pay when you get these services
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55-77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or a qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each freestanding radiological facility visit</p> <p>\$0 copayment for each outpatient hospital visit</p>


Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of "skilled nursing facility", see the chapter titled "Definitions of Important Words" of this booklet. Skilled nursing facilities are sometimes called "SNFs".)</p> <p>You are covered for medically necessary days 1-100 for each benefit period. Prior hospital stay is not required.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p>	<p>Per benefit period, you pay:</p> <p><u>In Network</u></p> <p>\$0 copayment per day, days 1-100</p> <p>\$0 copayment for physician services at a skilled nursing facility</p> <p>Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711)</p> <p><u>Out of Network</u></p> <p>\$0 copayment per day, days 1-100</p> <p>\$0 copayment for physician services at a skilled nursing facility</p> <p>Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711)</p>

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care (continued)</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital • Prior authorization is required for inpatient skilled nursing care <p>A new skilled nursing benefit period will begin on day one when you first enroll in a Humana Medicare Advantage plan, or you have been discharged from a skilled nursing facility (or not received inpatient skilled level of care) for 60 consecutive days.</p>	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you from a network provider. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</p> <p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p><u>In Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each outpatient hospital visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>You are covered for urgently needed services world-wide. If you have an urgent need for care while outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to Humana for reimbursement. For more information please see the chapter titled <i>"Asking us to pay our share of a bill you have received for covered medical services or drugs"</i>. We may not reimburse you for all out of pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.</p>	
<p><u>In Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p>	
<p><u>Out of Network</u></p> <p>\$0 copayment for each primary care physician's office visit</p> <p>\$0 copayment for each specialist's office visit</p> <p>\$0 copayment for each urgent care center visit</p>	

Services that are covered for you	What you must pay when you get these services
Vision services (Medicare-covered) Covered services include: <ul style="list-style-type: none"> ● Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. ● For people with diabetes, screening for diabetic retinopathy is covered once per year. ● One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. 	
	<u>In Network</u> \$0 copayment for each specialist's office visit \$0 copayment for eyeglasses and contact lenses following cataract surgery <u>Out of Network</u> \$0 copayment for each specialist's office visit \$0 copayment for eyeglasses and contact lenses following cataract surgery
 "Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	
	<u>In Network</u> \$0 copayment for each primary care physician's office visit <u>Out of Network</u> \$0 copayment for each primary care physician's office visit

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		<p>X</p> <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
<p>Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	X	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance)		<p>X</p> <p>Covered only when medically necessary</p>
<p>Experimental medical and surgical procedures, equipment and medications</p> <p>Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community</p>		<p>X</p> <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household	X	
Full-time nursing care in your home	X	

2022 Evidence of Coverage for Humana Group Medicare Advantage PPO Plan
Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	X	
Meals delivered to your home		X If included in the Well Dine benefit
Naturopath services (uses natural or alternative treatments)	X	
Non-routine dental care		X Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes		X If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
Personal items in your room at a hospital or skilled nursing facility, such as a telephone or a television	X	
Private duty nurses	X	
Private room in a hospital		X Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	X	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		X Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings or dentures	X	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		X Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery
Routine foot care		X Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids	X	
Services considered not reasonable and necessary, according to the standards of Original Medicare	X	
Services provided to veterans in Veterans Affairs (VA) facilities		X When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts
Supportive devices for the feet		X Orthopedic or therapeutic shoes for people with diabetic foot disease

CHAPTER 5

Asking us to pay our share of a bill you have
received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.4.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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 don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website at www.humana.com or call Customer Care and ask for the form. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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

Requests for payment for Medical Services:

Humana
P.O. Box 14168
Lexington, KY 40512-4168

Contact Customer Care if you have any questions. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

- Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)
- Section 1.2 We must ensure that you get timely access to your covered services
- Section 1.3 We must protect the privacy of your personal health information
- Section 1.4 We must give you information about the plan, its network of providers, and your covered services
- Section 1.5 We must support your right to make decisions about your care
- Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made
- Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?
- Section 1.8 How to get more information about your rights

SECTION 2 You have some responsibilities as a member of the plan

- Section 2.1 What are your responsibilities?

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Humana Grievances and Appeals Dept. at 1-800-457-4708. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact 1-800-457-4708 for additional information.

Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a Atención al Cliente. (Los números de teléfono del Atención al Cliente están en el Capítulo 2, Sección 1 de este folleto.)

Nuestro plan cuenta con personal y servicios gratuitos de intérpretes disponibles para responder preguntas de afiliados discapacitados y de los que no hablan inglés. También podemos darle información en braille, en letra grande o en otros formatos alternativos sin costo en caso de ser necesario. Se nos exige darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a Atención al cliente (los números de teléfono del Atención al Cliente están en el Capítulo 2, Sección 1 de este folleto).

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado, llame para presentar una queja formal ante el Departamento de quejas formales y apelaciones de Humana al 1-800-457-4708. También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto está incluida en esta *Evidencia de Cobertura* o en esta correspondencia, o puede contactar al 1-800-457-4708 para obtener información adicional.

Chapter 6. Your rights and responsibilities

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a primary care physician (PCP) in the plan's network. Call Customer Care to learn which doctors are accepting new patients. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

We make sure that unauthorized people don't see or change your records. In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

Chapter 6. Your rights and responsibilities

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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 may change our privacy practices and the terms of this notice at any time, as allowed by law. Including 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 includes both medical information and personal information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information. This includes information created or received by a health care provider or health plan. The information relates to your physical or mental health or condition, providing health care to you, or the payment for such health care.

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic, written and oral 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 employees about our privacy policies and programs

How do we use and disclose your information?

We 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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care 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 health care operation activities. Including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, 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. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission or your plan sponsor has to certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you if you have not opted out as described below, we will not contact you.
- 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. This applies if 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 if 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 that there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law

- To help with 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?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing. The following uses and disclosures will require your written permission:

- 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?

Your information may continue to be used for purposes described in this notice. This includes when 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?

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. You also may receive a summary of this health information. If you request copies, we may charge you a fee for the labor for copying, supplies for creating the copy (paper or electronic), and postage.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.

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- **Amendment** - You have the right to request an amendment of information we maintain about you if you believe that 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. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- **Notice** - You have the right to request and receive a written copy of this notice any.
- **Restriction** - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

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 forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our Website at www.humana.com and going to the Privacy Practices link

* This right applies only to our Massachusetts residents in accordance with state regulations.

- Send completed request form to:
Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

If I believe my privacy has been violated, what should I do?

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

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You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

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 protection.

We are required by law to abide by the terms of this notice currently in effect.

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

We are required by law to provide individuals with notice of our legal duties and privacy practices regarding personal and health information. If a breach of unsecured personal and health information occurs, we will notify you in a timely manner.

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

Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
DentiCare, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana Benefit Plan of Illinois, Inc.
Humana Benefit Plan of South Carolina, Inc.
Humana Benefit Plan of Texas, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company

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Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance 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 Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Go365 by Humana for Healthy Horizons
Managed Care Indemnity, Inc.
The Dental Concern, Inc.

Effective 9/2013

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A more complete picture of your health

Humana has developed programs that have the ability to deliver your electronic healthcare history to authorized healthcare providers. These healthcare providers can view your medical claims, pharmacy claims, laboratory claims and results and radiology claims and results via various information exchange programs. In addition, some of the medical information systems used by your healthcare providers may download your information to provide a more complete view of your health condition. For privacy reasons, records from psychiatric, substance abuse, or HIV-related treatment will not be shared.

The benefit of this information exchange is that healthcare providers receive a complete view of the healthcare services you have received. This information is available to a broad range of healthcare providers, including but not limited to:

- Primary Care Providers
- Medical Specialists
- Hospitals
- Urgent Care Centers
- Dental Providers
- Emergency Medical Service (EMS) Providers
- Selected Alternative and Complementary Medical Practices

For all residents outside of Massachusetts (MA) and New Mexico (NM):

You may use any of the methods listed below to decline your participation in the information sharing program *.

1. Log in to MyHumana - the secure section of www.humana.com
 - Select "My Profile" option located in the upper right-hand corner of the webpage.
 - Select the "Communications Preferences" option within the dropdown list.
 - Within the "Privacy and Sharing" section, select "No" to "Primary Care Physician (PCP) and Treating Healthcare Providers."
 - Click the "Save Changes" button at the bottom of the webpage.
2. Call the automated response line at 1-800-733-9203.
3. For TTY service, call 711. Our hours are Monday - Friday, 8 a.m. - 8 p.m. and Saturday, 8 a.m. - 3 p.m., Eastern time.

For all Massachusetts (MA) and New Mexico (NM) residents:

You may use any of the methods listed below to participate in the Payer-based Health Record information sharing program *.

1. Log in to MyHumana - the secure section of www.humana.com
 - Select "My Profile" option located in the upper right-hand corner of the webpage.
 - Select the "Communications Preferences" option within the dropdown list.
 - Within the "Privacy and Sharing" section, select "Yes" to "Primary Care Physician (PCP) and Treating Healthcare Providers."
 - Click the "Save Changes" button at the bottom of the webpage.
2. Call the automated response line at 1-800-733-9203.
3. For TTY service, call 711. Our hours are Monday - Friday, 8 a.m. - 8 p.m. and Saturday, 8 a.m. - 3 p.m., Eastern time.

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* There may be cases where Humana must exchange your health information to comply with regulatory requests and/or contractual agreements executed between Humana and a treating healthcare provider.

If you have any questions about how Humana protects your privacy, please access [**www.humana.com/about/legal/privacy**](http://www.humana.com/about/legal/privacy). If you do not have computer access, you can receive a copy of your Notice of Privacy Practices by calling the customer service phone number located on the back of your Humana ID card.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Humana Group Medicare Advantage PPO Plan you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
 - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *Provider Directory*.
 - For more detailed information about our providers, you can call Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) or visit our website at www.humana.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - We have special programs for members that focus on keeping you healthy, detecting early indicators of health risks, ensuring your care is delivered safely and efficiently across all levels of care, and managing chronic conditions. Also, our case management program offers supportive services to members with complicated medical conditions, or those who have been hospitalized. A Humana nurse helps you navigate the health care system and assists in coordinating care. Other programs help people manage health conditions like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and other illnesses. All of these programs are voluntary. If you qualify and are contacted about one of these special programs, we encourage you to participate as most members find these programs to be very helpful. You may choose to discontinue at any time by just letting your care manager know. If you would like more information about these special health programs, call the Nurse Advise Line team at 1-800-491-4164, TTY 711.

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- If you have questions about the rules or restrictions, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- **Information about why something is not covered and what you can do about it.**
 - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
 - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

We have a Quality Improvement (QI) program that focuses on clinical and preventive care and member service functions of the health plan. You may obtain a written Quality Improvement Progress Report that contains information on our Quality Improvement (QI) Program and how we are meeting our QI Program goals. It is available on Humana's website under Humana Medicare Plans. To request a printed copy or to provide input into the QI Program, mail a request to the following address: Humana Quality Operations and Compliance Department, Progress Report, 321 West Main, WFP 20, Louisville, KY 40202.

Section 1.5 We must support your right to make decisions about your care

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

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

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

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

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

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- 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 whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state's Quality Improvement Organization (QIO). Contact information can be found in "Exhibit A" in the back of this book.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

At Humana, a process called Utilization Management (UM) is used to determine whether a service or treatment is covered and appropriate for payment under your benefit plan. Humana does not reward or provide financial incentives to doctors, other individuals or Humana employees for denying coverage or encouraging under use of services. In fact, Humana works with your doctors and other providers to help you get the most appropriate care for your medical condition. If you have questions or concerns related to Utilization Management, staff are available at least eight hours a day during normal business hours. Humana has free language interpreter services available to answer questions related to Utilization Management from non-English speaking members. TTY/TDD users should call 1-800-457-4708 (TTY: 711).

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Chapter 6. Your rights and responsibilities

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the **Department of Health and Human Services Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care**. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can 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.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Care**. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) We're here to help.

Chapter 6. Your rights and responsibilities

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- ***If you have any other health insurance coverage in addition to our plan, you are required to tell us.*** Please call Customer Care to let us know. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** Show your plan membership card whenever you get your medical care.
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- ***Pay what you owe.*** As a plan member, you are responsible for these payments:
 - If you have a monthly plan premium, you must pay your plan premiums to continue being a member of our plan.

Chapter 6. Your rights and responsibilities

- In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
- For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
- If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)*
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- Call Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan and our rights and responsibilities statement.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

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Section 1.2 What about the legal terms?

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

COVERAGE DECISIONS AND APPEALS

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Section 4.1 Asking for coverage decisions and making appeals: the big picture

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Section 4.3 Which section in this chapter gives the details for your situation?

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

Section 7.2 We will tell you in advance when your coverage will be ending

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

SECTION 8 Taking your appeal to Level 3 and beyond

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MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

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Section 9.5 You can also tell Medicare about your complaint

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance", "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity". It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in "Exhibit A" at the end of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website www.medicare.gov/

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.
My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and making appeals."**

No.
My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances an appeal request will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss an appeal request, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Customer Care.** (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can get free help from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at <https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=639132>). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You can also get help or information from government organizations such as your State Health Insurance Assistance Program ("Exhibit A" at the end of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **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. Here's what to read in those situations:
 - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
If you want to ask us to pay you back for medical care or services you have already received and paid for.	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an "**organization determination**".

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "**fast coverage decision**".

Legal Terms

A "fast coverage decision" is called an "**expedited determination**".

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally, we use the standard deadlines for giving you our decision

When we give you our 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 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, for a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. 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. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

If your health requires it, ask us to give you a "fast coverage decision"

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However**, for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. 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. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
- 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 tells us that your health requires a "fast coverage decision", we will automatically agree to give you a fast coverage decision.

- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines 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 you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.

- As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. 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 9 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
- For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. 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 9 of this chapter.)
 - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period) or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan "reconsideration" .

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal"**.

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Customer Care (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at <https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=639132> While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms

A "fast appeal" is also called an "**expedited reconsideration**".

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal".
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision". To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal", we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
- However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. 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 9 of this chapter.)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization"**. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**". It is sometimes called the "**IRE**".

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- We will send the information about your appeal to this organization. This information is called your "case file". **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.

- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service the review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization, for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision". It is also called "turning down your appeal".)
 - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, 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 medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3 Go to this section for step-by-step instructions. 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 receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested 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 requested to you or to the provider within 60 calendar days.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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 care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**".
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

<p>Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</p>

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) 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.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

The written notice from Medicare tells you how you can **"request an immediate review"**. Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Care (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet) or 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 see the notice online at

www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization 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. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Contact information for your state Quality Improvement Organization (QIO) can be found in "Exhibit A" in the back of this document.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your 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* meet this deadline, 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 receive after your planned discharge date.
 - If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge appeal. 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

A "fast review" is also called an "immediate review" or an "expedited review".

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the "**Detailed Notice of Discharge**". You can get a sample of this notice by calling Customer Care (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet) 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 you can see a sample notice online at

www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the answer is no?

- If the review 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 to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- 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 another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a 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. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **We must** reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision".
- The notice you get will tell you in writing 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 the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

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.

Legal Terms

A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Contact us and ask for a "fast review".

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review"**. This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of 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 received after the planned discharge date.

Step 4: If we say no to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization"**. When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal". This organization decides whether the decision we made should be changed.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**". It is sometimes called the "**IRE**".

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (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 the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing 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 an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility", see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal"**. Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

Legal Terms

The written notice is called the **"Notice of Medicare Non-Coverage"**.

2. You will be asked to sign the written notice to show that you received it.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **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 9 tells you how to file a complaint.)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The **written notice you received tells you how to reach this organization.** (Or find the name, address, and phone number of the Quality Improvement Organization for your state in "Exhibit A" in the back of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by *noon of the day before* the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms

This notice of explanation is called the **"Detailed Explanation of Non-Coverage"**.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 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.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must** reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing 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 the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

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.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A "fast" review (or "fast appeal") is also called an "**expedited appeal**".

Step 1: Contact us and ask for a "fast review".

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review".** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization"**. When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal". This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**". It is sometimes called the "**IRE**".

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing 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.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an **Administrative Law Judge**) or an attorney adjudicator who works for the **Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not be over*** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not be over*.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not be over*** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not be over*.**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

IF YOU HAVE ANY OF THESE KINDS OF PROBLEMS, YOU CAN "MAKE A COMPLAINT"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Care has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by our Customer Care or other staff at the plan?

Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

Timeliness

(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal", and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

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| <ul style="list-style-type: none">• What this section calls a "complaint" is also called a "grievance".• Another term for "making a complaint" is "filing a grievance".• Another way to say "using the process for complaints" is "using the process for filing a grievance". |
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Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know. (Phone numbers for Customer Care can be located in Chapter 2, Section 1 of this booklet.)
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

Grievance Filing Instructions

File a verbal grievance by calling Customer Care. (Phone numbers for Customer Care are located in chapter 2, Section 1 of this booklet.) (TTY users should call 711.) We are available Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

Send a written grievance to:

Humana Grievances and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165

When filing a grievance, please provide:

- Name
- Address
- Telephone number
- Member identification number
- A summary of the complaint and any previous contact with us related to the complaint
- The action you are requesting from us
- A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care (phone numbers for Customer Care are located in chapter 2, Section 1 of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Option for Fast Review of your Grievance

You may request a fast review, and we will respond within 24 hours upon receipt, if your grievance concerns one of the following circumstances:

- We've extended the timeframe for making an organization determination/reconsiderations, and you believe you need a decision faster.
- We denied your request for a fast review of a 72-hour organization/coverage decision.
- We denied your request for a fast review of a 72-hour appeal.

It's best to call Customer Care if you want to request fast review of your grievance. If you mail your request, we'll call you to let you know we received it.

- **Whether you call or write, you should contact Customer Care right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **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.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms

What this section calls a "**fast complaint**" is also called an "**expedited grievance**".

Step 2: We look into your complaint and give you our answer.

- **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.
- **Most complaints are answered 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. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - 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 find the name, address, and phone number of the Quality Improvement Organization for your state, look in "Exhibit A" in the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to 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 issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

SECTION 2 When can you end your membership in our plan?

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

Section 2.2 Where can you get more information about when you can end your membership?

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

SECTION 5 Humana Group Medicare Advantage PPO Plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Section 5.3 You have the right to make a complaint if we end your membership in our plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Humana Group Medicare Advantage PPO Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. Contact Customer Care or your benefit administrator before you disenroll.

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Humana Group Medicare Advantage PPO Plan may be eligible to end their membership at other times of the year. This is known as a Special Enrollment Period.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website www.medicare.gov:
 - Usually, when you have moved.
 - If you have Medicaid.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
 - Where applicable, if you enroll in the Program of All-inclusive Care for Elderly (PACE).

Chapter 8. Ending your membership in the plan

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
 - Original Medicare *with* a separate Medicare prescription drug plan;
 - - or - Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Care**. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can find the information in the *Medicare & You 2022* handbook.
 - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website www.medicare.gov. Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **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.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Care or your benefit administrator if you need more information on how to do this. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- --or-- You can contact 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.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Another Medicare health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare health plan. You will automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage begins.
<ul style="list-style-type: none">• Original Medicare <i>with</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage begins.
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)• You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.• You will be disenrolled from Humana Group Medicare Advantage PPO Plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Humana Group Medicare Advantage PPO Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **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** (even if you are discharged after your new health coverage begins).

SECTION 5 Humana Group Medicare Advantage PPO Plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Humana Group Medicare Advantage PPO Plan must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- 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 area. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)
 - Go to Chapter 4, for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- 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. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

Chapter 8. Ending your membership in the plan

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Care** for more information. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Humana Group Medicare Advantage PPO Plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of 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.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

SECTION 2 Notice about non-discrimination

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

SECTION 5 Notice of coordination of benefits

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental, or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any third party that is responsible for the medical expenses or benefits related to your injury, illness, or condition. You assign to us your right to take legal action against any responsible third party, and you agree to:

Chapter 9. Legal notices

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 7.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 Notice of coordination of benefits

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all the rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan **and** our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Chapter 9. Legal notices

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or End Stage Renal Disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people who are disabled

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if:

- You are under age 65, and
- You do not have ESRD, and
- You do not have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple-employer plan where any employer participating in the plan has 100 or more employees. If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people with End Stage Renal Disease ("ESRD")

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to you thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

Chapter 9. Legal notices

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any health care costs related to your job-related illness or injury before we will provide any benefits under this *Evidence of Coverage* for services rendered in connection with your job-related illness or injury.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay," no-fault, automobile, accident, or liability coverage are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any health care costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment.

If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. We will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the **Additional Notice about Subrogation (Recovery from a Third Party)** section for more information on our recovery rights.

Chapter 9. Legal notices

More information

This is just a brief summary. Whether we pay first or second – or at all – depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "Medicare & Other Health Benefits: Your Guide to Who Pays First." It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this *Evidence of Coverage*.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Advanced Imaging Services - Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Allowed Amount - Individual charge determined by a carrier for a covered medical service or supply.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For our plan, you will have a benefit period for your skilled nursing facility benefits. For some plans, this may also include the inpatient hospital benefit if the plan has a deductible associated with that benefit. A benefit period begins on the first day you go into an inpatient hospital or a skilled nursing facility. The benefit period will accumulate one day for each day you are inpatient at a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any applicable deductibles. Coinsurance is usually a percentage (for example, 20%).

Chapter 10. Definitions of important words

Combined Maximum Out-of-Pocket Amount – If your plan has this feature, this is the most you will pay in a plan year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint - The formal name for "making a complaint" is "filing a grievance". The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance" in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Computed Tomography Imaging (CT/CAT) Scan - Combines the use of a digital computer together with a rotating X-ray device to create detailed cross-sectional images of different organs and body parts.

Contracted Rate - The rate the network provider has agreed to accept for covered services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

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

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Chapter 10. Definitions of important words

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Diagnostic Mammogram - A radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Chapter 10. Definitions of important words

Freestanding Dialysis Center - A freestanding facility that provides dialysis on an outpatient basis. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Freestanding Lab - A freestanding facility that provides laboratory tests on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Freestanding Radiology (Imaging) Center - A freestanding facility that provides one or more of the following services on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness: X-rays; nuclear medicine; radiation oncology. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Grievance - A type of complaint you make about us, or one of our network providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Maintenance Organization (HMO) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the network providers in the plan.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in Chapter 4 under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Chapter 10. Definitions of important words

Hospice Care - A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Humana's National Transplant Network (NTN) - A network of Humana-approved facilities all of which are also Medicare-approved facilities.

Income Related Monthly Adjustment Amount (IRMAA) - If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – If applicable for your plan, this is the most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket.

Inpatient Care - Health care that you get when you are admitted to a hospital.

Low Income Subsidy (LIS) – See "Extra Help."

Magnetic Resonance Angiography (MRA) - A noninvasive method and a form of magnetic resonance imaging (MRI) that can measure blood flow through blood vessels.

Chapter 10. Definitions of important words

Magnetic Resonance Imaging (MRI) - A diagnostic imaging modality method that uses a magnetic field and computerized analysis of induced radio frequency signals to noninvasively image body tissue.

Maximum Out-of-Pocket Amount - The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. 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 6 for information about how to contact Medicaid in your state.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Allowable Charge - The amount allowed by Medicare for a particular benefit or service.

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 B.

Chapter 10. Definitions of important words

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Limiting Charge - In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

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

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Non-Plan Provider or Non-Plan Facility - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Non-plan providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers may not be covered by our plan or Original Medicare.

Nuclear Medicine - Radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

Observation Services - are hospital outpatient services given to help the doctor decide if a patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital. Even if you stay overnight in a regular hospital bed, you might be an outpatient.

Chapter 10. Definitions of important words

Organization Determination - The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 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, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Our plan – The plan you are enrolled in.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – see "Medicare Advantage (MA) Plan."

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

Plan Provider – see "Network Provider".

Point-of-Service (POS) Plan - A Medicare managed care plan option that lets you use doctors and hospitals outside the plan for an additional cost.

Positron Emission Tomography (PET) Scan - A medical imaging technique that involves injecting the patient with an isotope and using a PET scanner to detect the radiation emitted.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care physician 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 keep you 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 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get services. Some network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

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 practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram - A radiological procedure for early detection of breast cancer, and; includes a physician's interpretation of the results.

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's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

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 injections that can only be given by a registered nurse or doctor.

Chapter 10. Definitions of important words

Special Enrollment Period - A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan - A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgent Care Center - A facility established to diagnose and treat an unforeseen injury or illness on an outpatient basis. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board.

Urgently Needed Services - Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

2022 Evidence of Coverage for Humana Group Medicare Advantage PPO Plan
Exhibit A: State Agency Contact Information

ALABAMA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Alabama Department of Senior Services 201 Monroe St., Suite 350, Montgomery, AL 36104 1-800-243-5463 (1-800-AGELINE)(toll free) 1-334-242-5594 (fax) http://www.alabamaageline.gov/
SMO	Alabama Medicaid Agency 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624 1-800-362-1504 (toll free) 1-334-242-5000 (local) http://www.medicaid.alabama.gov/
SPAP	Not Applicable
ADAP	Alabama AIDS Drug Assistance Programs, HIV/AIDS Division Alabama Department of Public Health The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104 1-866-574-9964 1-334-206-6221 (fax) http://www.alabamapublichealth.gov/hiv/adap.html
ALASKA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Alaska State Health Insurance Assistance Programs (SHIP) 550 W. 7th Ave., Suite 1230, Anchorage, AK 99501 1-800-478-6065 (toll free) 1-907-269-7800 (local) 1-800-770-8973 (TTY)(toll free) www.medicare.alaska.gov
SMO	Alaska Department of Health and Social Services 350 Main Street Room 304, P.O. Box 110640, Juneau, AK 99811 1-800-780-9972 (toll free) 1-907-465-3030 (local) 1-907-465-3068 (fax) www.dhss.alaska.gov/dpa
SPAP	Not Applicable
ADAP	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Ste 102, Anchorage, AK 99503 1-800-478-2437 1-907-263-2051 (fax) www.alaskanids.org/index.php/client-services/adap
ARIZONA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)

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Exhibit A: State Agency Contact Information

SHIP	<p>Arizona State Health Insurance Assistance Program (SHIP) 1789 West Jefferson St., (Site Code 950A), Phoenix, AZ 85007 1-800-432-4040 (toll free) (Spanish available upon request) 1-602-542-4446 (local) 711 (TTY) https://des.az.gov/services/older-adults/medicare-assistance</p>
SMO	<p>Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St., Phoenix, AZ 85034 1-800-523-0231 (toll free) 1-602-417-4000 (local) 1-602-252-6536 (fax) 1-602-417-4000 (Spanish) http://www.azahcccs.gov/</p>
SPAP	Not Applicable
ADAP	<p>Office of Disease Integration and Services, Arizona Department of Health Services 150 North 18th Avenue Suite 110, Phoenix, AZ 85007 1-800-334-1540 1-602-364-3610 1-602-364-3263 (fax) https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home</p>
ARKANSAS	
QIO	<p>KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)</p>
SHIP	<p>Senior Health Insurance Information Program (SHIIP) 1 Commerce Way, Little Rock, AR 72202 1-800-282-9134 (toll free) 1-501-371-2782 (local) 1-501-371-2781 (fax) 1-501-683-4468 (TTY) www.insurance.arkansas.gov/pages/consumer-services/senior-health/</p>
SMO	<p>Arkansas Medicaid Donaghey Plaza South, P.O. Box 1437 Slot S401, Little Rock, AR 72203-1437 1-800-482-5431 (toll free) 1-501-682-8233 (local) 1-800-482-8988 (Spanish) 1-501-682-8820 (TTY) www.medicaid.mmis.arkansas.gov/</p>
SPAP	Not Applicable
ADAP	<p>Arkansas AIDS Drug Assistance Program, Arkansas Department of Health 4815 West Markham Street; Slot 33, Little Rock, AR 72205 1-501-661-2408 1-501-661-2082 (fax) www.healthy.arkansas.gov/programs-services/topics/ryan-white-program</p>

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CALIFORNIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Drive, Suite 200, Sacramento, CA 95834-1992 1-800-434-0222 (toll free) 1-916-928-2267 (fax) 1-800-735-2929 (TTY) www.aging.ca.gov/HICAP/
SMO	Medi-Cal (Medicaid) P.O. Box 997413 MS 4400, Sacramento, CA 95899-7413 1-800-541-5555 (toll free) 1-916-636-1980 (local) www.medi-cal.ca.gov/
SPAP	Not Applicable
ADAP	AIDS Drug Assistance Program California Department of Public Health, Office of AIDS MS 7700, P.O. Box 997426, Sacramento, CA 95899 1-844-421-7050 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx
COLORADO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850, Denver, CO 80202 1-800-886-7675 (toll free) 1-866-665-9668 (Spanish) 1-303-894-7880 (TTY) www.colorado.gov/dora/division-insurance
SMO	Health First Colorado 1570 Grant Street, Denver, CO 80203-1818 1-800-221-3943 (toll free) 1-303-866-2993 (local) 1-303-866-4411 (fax) www.colorado.gov/hcpf
SPAP	Colorado Bridging the Gap, Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South, Denver, CO 80246 1-303-692-2783 (local) 1-303-692-2716 (local) https://www.colorado.gov/pacific/cdphe/prevention-care
ADAP	Colorado AIDS Drug Assistance Program CDPHE Care and Treatment Program ADAP 4300 Cherry Creek Drive South, Denver, CO 80246-1530 1-303-692-2716 1-303-691-7736 (fax) https://www.colorado.gov/pacific/cdphe/prevention-care

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Exhibit A: State Agency Contact Information

CONNECTICUT	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)</p>
SHIP	<p>CHOICES 55 Farmington Avenue, 12th Floor, Hartford, CT 06105-3730 1-800-994-9422 (toll free for in-state) 1-866-218-6631 (out of state callers) 1-860-424-4850 (fax) 1-860-247-0775 (toll free TTY) www.ct.gov/agingservices</p>
SMO	<p>HUSKY Health Connecticut 55 Farmington Avenue, Hartford, CT 06105-3730 1-855-626-6632 (toll free) 1-860-424-4908 (local) 1-800-842-4524 (TTY) www.ct.gov/dss/site/default.asp</p>
SPAP	<p>Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE) P.O. Box 5011, Hartford, CT 06102 1-800-423-5026 (toll free) 1-860-269-2029 (local) www.payingforseniorcare.com/prescription-drugs/assistance-for-the-elderly.html</p>
ADAP	<p>Connecticut AIDS Drug Assistance Program (CADAP) Department of Social Services Medical Operations Unit #4 25 Sigourney Street, Hartford, CT 06106-5033 1-800-233-2503 (toll free) www.portal.ct.gov/DSS/Health-And-Home-Care/CADAP/Connecticut-AID S-Drug-Assistance-Program-CADAP</p>
DELAWARE	
QIO	<p>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)</p>
SHIP	<p>Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street Suite 101, Dover, DE 19904 1-800-336-9500 (toll free) 1-302-674-7364 (local) https://insurance.delaware.gov/divisions/dmab/</p>
SMO	<p>Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 N. DuPont Highway, New Castle, DE 19720 1-800-372-2022 (toll free) 1-302-255-9500 (local) 1-302-255-4429 (fax) http://www.dhss.delaware.gov/dhss/dmma/</p>

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SPAP	Delaware Chronic Renal Disease Program 11-13 North Church Ave, Milford, DE 19963 0950 1-800-464-4357 (toll free) 1-302-424-7180 https://www.dhss.delaware.gov/dhss/dmma/crdprog.html
ADAP	Delaware HIV Consortium Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901 1-302-744-1050 1-302-739-2548 (fax) http://www.ramsellcorp.com/medical_professionals/de.aspx
DISTRICT OF COLUMBIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Health Insurance Counseling Project (HICP) 500 K Street, NE, Washington, DC 20002 1-202-724-5626 (local) 711 (TTY) 1-202-724-2008 (fax) https://dcoa.dc.gov/service/health-insurance-counseling
SMO	Department of Health- District of Columbia 899 North Capitol Street NE, Washington, DC 20002 1-855-532-5465 (toll free) 1-202-442-5955 (local) 1-202-442-4795 (fax) 711 (TTY) http://www.doh.dc.gov/
SPAP	Not Applicable
ADAP	DC AIDS Drug Assistance Program District of Columbia Department of Health 899 North Capitol Street N.E. 4th floor, Washington, DC 20002 1-202-671-4900 1-202-673-4365 (fax) 1-202-671-4815 (DC ADAP Hotline) https://www.dchealth.dc.gov/DC-ADAP
FLORIDA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000 1-800-963-5337 (toll free/llamada gratuito) 1-850-414-2150 (fax) 1-800-955-8770 (TTY) www.floridaSHINE.org

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SMO	Florida Medicaid 1317 Winewood Blvd. Building 1, Room 202, Tallahassee, FL 32399-0700 1-866-762-2237 (toll free/llamada gratuito) 1-850-487-1111 (local) 1-850-922-2993 (fax) www.ahca.myflorida.com/
SPAP	Not Applicable/No corresponde
ADAP	Florida ADAP Program, HIV/AIDS Section 4052 Bald Cypress Way, Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (español) 1-800-2437-101 (1-800-AIDS-101) (Creole/Kreyòl Ayisiyen) 1-888-503-7118 (TTY) www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html
GEORGIA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	GeorgiaCares 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303 1-866-552-4464 (Option 4) 1-404-657-1929 (TTY) http://www.mygeorgiacares.org/
SMO	Georgia Department of Community Health (DCH) (Medicaid) 2 Peachtree Street NW, Atlanta, GA 30303 1-800-436-7442 (toll free) 1-404-656-4507 (local) http://www.dch.georgia.gov/
SPAP	Not Applicable
ADAP	Georgia AIDS Drug Assistance Program Georgia Department of Public Health 2 Peachtree St. NW, Atlanta, GA 30303-3186 1-404-656-9805 https://dph.georgia.gov/aids-drug-assistance-program-adap-0
HAWAII	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	Sage PLUS Program Executive Office on Aging No. 1 Capitol District 250 South Hotel St., Suite 406, Honolulu, HI 96813-2831 1-888-875-9229 (toll free) 1-808-586-7299 (local) 1-808-586-0185 (fax) 1-866-810-4379 (toll free TTY) http://www.hawaiiiship.org/

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SMO	Med QUEST 801 Dillingham Boulevard, 3rd Floor, Honolulu, HI 96817-4582 1-800-316-8005 (toll free) 1-808-524-3370 (local) 1-800-603-1201 (TTY) 1-800-316-8005 (Spanish) http://www.med-quest.us/
SPAP	Not Applicable
ADAP	HDAP, Harm Reduction Services Branch 728 Sunset Avenue, Honolulu, HI 96816 1-808-733-9360 http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/
IDAHO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefit Advisors (SHIBA) 700 West State Street 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043 1-800-247-4422 (toll free) 1-208-334-4389 (fax) www.doi.idaho.gov/SHIBA
SMO	Idaho Health Plan Coverage P.O. Box 83720, Boise, ID 83720 1-877-456-1233 (toll free) 1-208-334-6700 (local) 1-866-434-8278 (fax) www.healthandwelfare.idaho.gov/
SPAP	Idaho AIDS Drug Assistance Program (IDAGAP), Department of Health and Welfare P. O. Box 83720, Boise, ID 83720 1-800-926-2588 (toll free) 1-208-334-5943 (local) www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
ADAP	Idaho ADAP, Idaho Ryan White Part B Program 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036 1-208-334-5612 1-208-332-7346 (fax) https://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx
ILLINOIS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)

Exhibit A: State Agency Contact Information

SHIP	Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100, Springfield, IL 62702-1271 1-800-252-8966 (toll free) 1-888-206-1327 (TTY) www.illinois.gov/aging/SHIP
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Exhibit A: State Agency Contact Information

SMO	Medical Assistance Program 100 South Grand Avenue East, Springfield, IL 62762 1-800-226-0768 (toll free) 1-217-782-4977(local) 1-800- 526-5812 (toll free TTY) 1-800-547-0466 (TTY) www.illinois.gov/hfs/Pages/default.aspx
SPAP	Not Applicable
ADAP	Illinois AIDS Drug Assistance Program, Illinois ADAP Office 525 West Jefferson Street First Floor, Springfield, IL 62761 1-217-524-5983 1-800-825-3518 (fax) 217-785-8013 (fax) www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
INDIANA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787 1-800-452-4800 (toll free) 1-765-608-2318 (local) 1-866-846-0139 (toll free TTY) http://www.in.gov/ship
SMO	Indiana Medicaid 402 West Washington Street, P.O. Box 7083, Indianapolis, IN 46204-7083 1-800-403-0864 (toll free) 1-317-233-4454 (local) 1-317-232-7867 (fax) http://www.in.gov/fssa/
SPAP	Hoosier RX 402 W. Washington St., Room W374 MS07, Indianapolis, IN 46204 1-866-267-4679 (toll free) 1-317-234-1381 (local) https://www.in.gov/fssa/ompp/3526.htm
ADAP	Indiana AIDS Drug Assistance Program Indiana State Department of Health 2 N Meridian St., Suite 6C, Indianapolis, IN 46204 1-866-588-4948 http://www.in.gov/isdh/17740.htm
IOWA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue Suite 100, Des Moines, IA 50315 1-800-351-4664 (toll free) 1-800-735-2942 (toll free TTY) https://shiip.iowa.gov/

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Exhibit A: State Agency Contact Information

SMO	IA Health Link 1305 E Walnut St, Des Moines, IA 50319 1-800-338-8366 (toll free) 1-515-256-4606 (local) 1-515-725-1351 (fax) 1-800-735-2942 (TTY) http://www.dhs.iowa.gov/iahealthlink
SPAP	Not Applicable
ADAP	Iowa AIDS Drug Assistance Program, Iowa Department of Public Health 321 E. 12th Street, Des Moines, IA 50319-0075 1-515-725-2011 http://www.idph.iowa.gov/hivstdhep/hiv/support
KANSAS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	Senior Health Insurance Counseling for Kansas (SHICK) New England Building 503 S. Kansas Avenue, Topeka, KS 66603 1-800-860-5260 (toll free) 1-785-296-0256 (fax) http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs
SMO	DCR (Formerly Department of Social and Rehabilitation Services of Kansas) Curtis State Office Building, 1000 SW Jackson, Topeka, KS 66612 1-800-766-9012 (toll free) 1-785-296-1500 (local) http://www.kdheks.gov/
SPAP	Not Applicable
ADAP	Kansas AIDS Drug Assistance Program (ADAP) Curtis State Office Building, 1000 SW Jackson Suite 210, Topeka, KS 66612 1-785-296-6174 1-785-559-4225 (fax) http://www.kdheks.gov/sti_hiv/ryan_white_care.htm
KENTUCKY	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3E-E, Frankfort, KY 40621 1-877-293-7447 (toll free) 1-502-564-6930 (local) https://www.chfs.ky.gov/agencies/dail/Pages/ship.aspx

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SMO	Department for Medicaid Services (DMS) 275 East Main Street, Frankfort, KY 40621 1-800-635-2570 (toll free) 1-502-564-4321 (local) http://www.chfs.ky.gov
SPAP	Not Applicable
ADAP	Kentucky AIDS Drug Assistance Program (KADAP) Kentucky Cabinet for Public Health and Family Services 275 East Main Street HS2E-C, Frankfort, KY 40621 1-800-420-7431 1-502-564-9865 (fax) https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx
LOUISIANA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street, Baton Rouge, LA 70802 1-800-259-5300 (toll free) 1-225-342-5301 (local) http://www.ldi.la.gov/SHIIP/
SMO	Healthy Louisiana (Medicaid) Healthy Louisiana P.O. Box 629, Baton Rouge, LA 70821-0629 1-888-342-6207 (toll free) 1-855-229-6848 (local) 1-877-252-2447 (Spanish) 1-855-526-3346 (TTY) https://ldh.la.gov/
SPAP	Not Applicable
ADAP	Louisiana AIDS Drug Assistance Program (L-DAP) Department of Health & Hospitals Louisiana Health Access Program (LA HAP) 1450 Poydras St Suite 2136, New Orleans, LA 70112 1-504-568-7474 1-504-568-3157 (fax) http://www.lahap.org
MAINE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street, 11 State House Station, Augusta, ME 04333 1-800-262-2232 (toll free) Maine relay 711 (TTY) www.maine.gov/dhhs/oads/community-support/ship.html
SMO	Maine Department of Health and Human Services (Medicaid) 109 Capitol St, Augusta, ME 04333-0011 1-800-977-6740 (toll free) 1-207-287-3707 (local) 1-207-287-3005 (fax) 711 (TTY) www.maine.gov/dhhs/

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SPAP	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 242 State Street, Augusta, ME 04333 1-866-796-2463 https://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/index.html
ADAP	Maine Ryan White Program 40 State House Station, Augusta, ME 04330 1-207-287-3747 1-207-287-3727 (fax) www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
MARYLAND	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007, Baltimore, MD 21201 1-800-243-3425 (toll free) 1-410-767-1100 (local) 1-844-627-5465 (out of state) 711 (TTY) https://aging.maryland.gov/Pages/state-health-insurance-program.aspx
SMO	Maryland Department of Health and Mental Hygiene 201 W. Preston St., Baltimore, MD 21201-2399 1-877-463-3464 (toll free) 1-410-767-6500 (local) 1-855-642-8573 (TTY) https://health.maryland.gov/pages/home.aspx
SPAP	Maryland Senior Prescription Drug Assistance Program Maryland SPDAP c/o Pool Administrators 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033 1-800-551-5995 (toll free) 1-410-767-5000 (local) www.marylandspdap.com
ADAP	Prevention and Health Promotion Administration 500 N Calvert St 5th Floor, Baltimore, MD 21202 1-410-767-6535 1-410-333-2608 (fax) https://phpa.health.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx
MASSACHUSETTS	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Serving Health Information Needs of Elders (SHINE) One Ashburton Place, 5 floor, Boston, MA 02108 1-800-243-4636 (toll free) 1-617-727-7750 (local) 1-617-727-9368 (fax) 1-877-610-0241 (toll free TTY) https://www.mass.gov/orgs/executive-office-of-elder-affairs

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SMO	MassHealth 100 Hancock Street, 6th Floor, Quincy, MA 02171 1-800-841-2900 (toll free) 1-800-497-4648 (TTY) http://www.mass.gov/masshealth
SPAP	Massachusetts Prescription Advantage P.O. Box 15153, Worcester, MA 01615 1-800-243-4636 ext. 2 (toll free) http://www.mass.gov/elders/healthcare/prescription-advantage/
ADAP	Community Research Initiative of New England 529 Main Street Suite 301, Boston, MA 02129 1-617-502-1700 1-617-502-1703 (fax) http://crine.org/hdap
MICHIGAN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	MMAP, Inc. 6105 West St. Joseph Hwy, Suite 204, Lansing, MI 48917 1-800-803-7174 (toll free) www.mmapinc.org
SMO	Michigan Department of Health and Human Services (Medicaid) Capitol View Building, 201 Townsend Street, Lansing, MI 48913 1-800-642-3195 (toll free) 1-517-241-2966 (local) 1-800-649-3777 (TTY) www.michigan.gov/mdhhs
SPAP	Not Applicable
ADAP	Michigan AIDS Drug Assistance Program (MIDAP) Michigan Department of Health and Human Services Division of Health, Wellness and Disease Control, 109 Michigan Avenue 9th Floor, Lansing, MI 48913 1-888-826-6565 1-517-335-7723 (fax) www.michigan.gov/mdch/
MINNESOTA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street, PO Box 64976, St. Paul, MN 55164 1-800-333-2433 (toll free) www.health.state.mn.us/ship/

Exhibit A: State Agency Contact Information

SMO	Department of Human Services of Minnesota -MinnesotaCare P.O. Box 64838, St. Paul, MN 55164-0838 1-800-657-3672 (toll free) 1-651-297-3862 (local) 1-651-282-5100 (fax) www.mn.gov/dhs/
SPAP	Not Applicable
ADAP	Minnesota AIDS Drug Assistance Program P.O. Box 64972, St. Paul, MN 55164 1-651-431-2414 1-651-431-7414 (fax) www.mn.gov/dhs/
MISSISSIPPI	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	MS Dept of Human Services - Division of Aging & Adult Services 200 South Lamar St., Jackson, Jackson, MS 39201 1-844-822-4622 (toll free) 1-601-359-4577 (local) 1-787-919-7291 (TTY) www.mdhs.ms.gov/adults-seniors/
SMO	Mississippi Division of Medicaid 550 High Street, Suite 1000, Jackson, MS 39201 1-800-421-2408 (toll free) 1-601-359-6050 (local) 1-601-359-6048 (fax) 1-228-206-6062 (Video Phone) www.medicaid.ms.gov/
SPAP	Not Applicable
ADAP	Mississippi AIDS Drug Assistance Program Office of STD/HIV Care and Services Division Post Office Box 1700, Jackson, MS 39215-1700 1-888-343-7373 1-601-362-4782(fax) http://msdh.ms.gov
MISSOURI	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	CLAIM 1105 Lakeview Avenue, Columbia, MO 65201 1-800-390-3330 (toll free) 1-573-817-8320 (local) http://www.missouricclaim.org

Exhibit A: State Agency Contact Information

SMO	MO HealthNet (Medicaid) 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500 1-855-373-4636 (toll free) 1-573-751-3425 (local) 1-800-735-2966 (TTY) http://www.dss.mo.gov/fsd/index.htm
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SPAP	Missouri RX Plan P.O. Box 6500, Jefferson City, MO 65102 1-800-375-1406 (toll free) www.morx.mo.gov/
ADAP	Missouri AIDS Drug Assistance Program Bureau of HIV, STD, and Hepatitis Missouri Department of Health & Senior Services P.O. Box 570, Jefferson City, MO 65102-0570 1-573-751-6439 1-573-751-6447 (fax) http://www.health.mo.gov/living/healthcondiseases/communicable/hiv aids/casemgmt.php
MONTANA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave, Helena, MT 59601 1-800-551-3191 (toll free) http://www.dphhs.mt.gov/sltc/aging/SHIP.aspx
SMO	State of Montana Department of Public Health and Human Services (Medicaid) 1400 Broadway Cogswell Building, P.O. Box 202951, Helena, MT 59601-8005 1-800-362-8312 (toll free) 1-406-444-4455 (local) 1-406-444-1861 (fax) http://www.dphhs.mt.gov/
SPAP	Montana Big Sky RX Program P.O. Box 202915, Helena, MT 59620 1-866-369-1233 (toll free- In State) 1-406-444-1233 (local) http://www.dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx
ADAP	Montana AIDS Drug Assistance Program Montana Department of Public Health and Human Services Cosswell Bldg. C – 211, 1400 Broadway, Helena, MT 59620-2951 1-406-444-3565 1-406-444-6842 (fax) http://www.dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx
NEBRASKA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)

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SHIP	Nebraska Senior Health Insurance Information Program (SHIIP) 1033 O Street, Suite 307, Lincoln, NE 68508 1-800-234-7119 (toll free) 1-402-471-2841(local) 1-800-833-7352 (toll free TTY) 1-800-234-7119 (llamada gratuita) http://www.doi.nebraska.gov/shiip/
SMO	Nebraska Department of Health and Human Services (Medicaid) P.O. Box 95026, Lincoln, NE 68509 1-855-632-7633 (toll free) 1-402-471-3121 (local) 1-800-833-7352 (TTY) 1-402-471-9209 (fax) http://www.dhhs.ne.gov/Pages/default.aspx
SPAP	Not Applicable
ADAP	Nebraska AIDS Drug Assistance Program Nebraska Department of Health & Human Services 301 Centennial Mall South, Lincoln, NE 68509 1-402-471-2101 1-402-553-5527 (fax) www.dhhs.ne.gov/Pages/Ryan-White.aspx
NEVADA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 (toll free) 1-833-868-4063 (fax) 1-855-887-6668 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) 1860 E Sahara Avenue, Suite 205, Las Vegas, NV 89104 1-800-307-4444 (toll free) 1-702-486-3478 (local) https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
SMO	Department of Health and Human Services Division of Health Care Financing and Policy, 1100 E. William Street, Carson City, NV 89701 1-800-992-0900 (toll free) 1-702-631-7098 (local) www.dwss.nv.gov
SPAP	Nevada Senior Rx Program Nevada Senior Rx Dept of Health and Human Services 3416 Goni Road Suite D-132, Carson City, NV 89706 1-866-303-6323 (toll free) 1-775-687-4210 (local) http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
ADAP	Nevada AIDS Drug Assistance Program Office of HIV/AIDS 4126 Technology Way Suite 200, Carson City, NV 89706 1-775-684-5928 1-775-684-4056 (fax) http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/

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NEW HAMPSHIRE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	NH SHIP - ServiceLink Aging and Disability Resource Center 129 Pleasant Street, Concord, NH 03301-3857 1-866-634-9412 (toll free) https://www.servicelink.nh.gov/medicare/index.htm
SMO	New Hampshire Medicaid 129 Pleasant Street, Concord, NH 03301 1-844-275-3447 (toll free) 1-603-271-4344 (local) 1-800-735-2964 (toll free TTY) www.dhhs.nh.gov/
SPAP	Not Applicable
ADAP	New Hampshire AIDS Drug Assistance Program DHHS- NH CARE Program, 29 Hazen Drive, Concord, NH 03301 1-800-852-3345 ext. 4502 1-603-271-4934 (fax) 1-603-271-4502 www.dhhs.nh.gov
NEW JERSEY	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 (toll free) 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) P.O. Box 715, Trenton, NJ 08625 0715 1-800-792-8820 (toll free) 1-877-222-3737 (out of state) http://www.state.nj.us/humanservices/doas/services/ship/index.html
SMO	NH Family Care P.O. Box 712, Trenton, NJ 08625-0712 1-800-356-1561 (toll free) 1-877-294-4356 (TTY) http://www.state.nj.us/humanservices/dmahs
SPAP	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services Senior Gold Discount Program, P.O. Box 715, Trenton, NJ 08625 1-800-792-9745 (toll free) http://www.state.nj.us/humanservices/doas/services/seniorgold/
ADAP	New Jersey AIDS Drug Assistance Program New Jersey ADDP Office, P.O. Box 722, Trenton, NJ 08625-0722 1-877-613-4533 1-609-588-7037 (fax) http://www.state.nj.us/health/aids

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NEW MEXICO	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	New Mexico ADRC 2550 Cerrillos Road, Santa Fe, NM 87505 1-800-432-2080 (toll free) 1-505-476-4846 (local) www.nmaging.state.nm.us/
SMO	Department of Human Services of New Mexico P.O. Box 2348, Santa Fe, NM 87504-2348 1-888-997-2583 (toll free) 1-505-827-3100 (local) 1-800-432-6217 (Spanish) 1-855-227-5485 (TTY) www.newmexico.gov/
SPAP	Not Applicable
ADAP	New Mexico AIDS Drug Assistance Program, HIV Services Program 1190 S St. Francis Dr. Suite 2-1200, Santa Fe, NM 87502 1-505-476-3628 1-505-827-0561 (fax) www.nmhealth.org/about/phd/idb/hats/
NEW YORK	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, Albany, NY 12223-1251 1-800-701-0501 (toll free) https://aging.ny.gov/health-insurance-information-counseling-and-assistance
SMO	New York State Department of Health (SDOH) (Medicaid), Office of Medicaid Management 800 North Pearl Street, Albany, NY 12204 1-800-541-2831 (toll free) 1-518-473-3782 (local) www.omig.ny.gov
SPAP	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) EPIC P.O. Box 15018, Albany, NY 12212-5018 1-800-332-3742 (toll free) www.health.state.ny.us/nysdoh/epic/faq.htm
ADAP	New York AIDS Drug Assistance Program HIV Uninsured Care Programs Empire Station P.O. Box 2052, Albany, NY 12220 1-800-542-2437 (or 1-844-682-4058 (toll-free)) 1-518-459-0121 (TDD) www.health.ny.gov/diseases/aids/general/resources/adap

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NORTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Seniors' Health Insurance Information Program (SHIIP) 325 N. Salisbury Street, Raleigh, NC 27603 1-855-408-1212 (toll free) 1-919-807-6900 (local) 1-919-807-6901 (fax) http://www.ncdoi.com/SHIIP/Default.aspx
SMO	North Carolina, Division of Health Benefits (Medicaid) 2501 Mail Service Center, Raleigh, NC 27699-2501 1-800-662-7030 (toll free) 1-919-855-4100 (local) 1-919-733-6608 (fax) https://www.dma.ncdhhs.gov/
SPAP	North Carolina HIV SPAP 1902 Mail Service Center, Raleigh, NC 27699 1-877-466-2232 (toll free) 1-919-733-7301 (local) https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
ADAP	North Carolina AIDS Drug Assistance Program NC Department of Health and Human Services Division of Public Health Epidemiology Section Communicable Disease Branch 1907 Mail Service Center, Raleigh, NC 27699-1902 1-877-466-2232 (toll free) (in state) 1-919-733-0490 (fax) 1-877-466-2232 (toll free) http://epi.publichealth.nc.gov/cd/hiv/hmap.html
NORTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Counseling (SHIC) North Dakota Insurance Department, 600 East Boulevard Ave. Bismarck, ND 58505-0320 1-888-575-6611 (toll free) 1-701-328-2440 (local) 1-701-328-4880 (fax) 1-800-366-6888 (TTY) www.nd.gov/ndins/shic
SMO	North Dakota Department of Human Resources 600 East Blvd. Ave, Dept. 325, Bismarck, ND 58505-0250 1-800-755-2604 (toll free) 1-701-328-7068 (local) 1-701-328-1544 (fax) 1-800-366-6888 (TTY) www.nd.gov/dhs/
SPAP	Not Applicable

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ADAP	North Dakota AIDS Drug Assistance Program, North Dakota Department of Health 2635 E. Main Avenue P.O. Box 5520, Bismarck, ND 58506-5520 1-701-328-2378 1-701-328-0338 1-800-472-2180 (toll free) www.ndhealth.gov/HIV
OHIO	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town Street, 3rd floor Suite 300, Columbus, OH 43215 1-800-686-1578 (toll free) 1-614-644-3745 (TTY) www.insurance.ohio.gov
SMO	Ohio Department of Medicaid (ODM) 50 West Town Street, Suite 400, Columbus, OH 43215 1-800-324-8680 (toll free) 1-614-466-1213 (local) www.medicaid.ohio.gov/
SPAP	Not Applicable
ADAP	Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health HIV Care Services Section Ohio HIV Drug Assistance Program (OHDAP), 246 N. High Street, Columbus, OH 43215 1-800-777-4775 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
OKLAHOMA	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Oklahoma Medicare Assistance Program (MAP) Five Corporate Plaza 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112 1-800-763-2828 (toll free) (in state only) 1-405-521-6628 (local) (out of state only) https://www.ok.gov/oid/Consumers/Information for Seniors/index.html
SMO	Oklahoma Health Care Authority (OHCA) (Medicaid) 4345 N. Lincoln Blvd., Oklahoma City, OK 73105 1-800-522-0310 (toll free) 1-405-522-7300 (local) 1-405-522-7100 (fax) http://www.okhca.org/
SPAP	Not Applicable

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ADAP	Oklahoma AIDS Drug Assistance Program HIV/STD Services Division Oklahoma State Department of Health 1000 N.E. Tenth St., Mail Drop 0308, Oklahoma City, OK 73117-1299 1-405-271-4636 1-405-271-5149 (fax) https://www.ok.gov/health/Prevention_and_Preparedness/HIV_STD_Service/index.html
OREGON	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480, Salem, OR 97309 1-800-722-4134 (toll free) 1-503-947-7979 (local) https://healthcare.oregon.gov/shiba/pages/index.aspx
SMO	Oregon Health Authority 500 Summer Street NE,E-15, Salem, OR 97301 1-800-375-2863 (toll free) 1-503-947-2340 (local) 1-503-947-5461 (fax) 1-503-945-6214 (TTY) www.oregon.gov/oha
SPAP	Not Applicable
ADAP	Oregon AIDS Drug Assistance Program (ADAP) CAREAssist Program 800 NE Oregon Street Suite 1105, Portland, OR 97232 1-971-673-0144 1-971-673-0177 (fax) http://www.public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment
PENNSYLVANIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	APPRISE 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919 1-800-783-7067 (toll free) 1-717-783-1550 (local) www.aging.state.pa.us
SMO	Pennsylvania Department of Human Services (Medicaid) 625 Forster St, Harrisburg, PA 17120 1-800-692-7462 (toll free) 1-800-451-5886 (TTY) www.dhs.pa.gov
SPAP	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/Pacenet Program, P.O. Box 8806, Harrisburg, PA 17105 1-800-225-7223 (toll free) 1-717-651-3600 (local) https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Exhibit A: State Agency Contact Information

ADAP	<p>Pennsylvania AIDS Drug Assistance Program (ADAP) Pennsylvania Department of Health Special Pharmaceutical Benefits Program 625 Forster Street, H&W Bldg, Rm 611 Harrisburg, PA 17120 1-800-922-9384 1-888-656-0372 (fax) www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx#.V1IcIKPD9es</p>
PUERTO RICO	
QIO	<p>Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 1-833-868-4056 (fax) 1-866-868-2289 (TTY) www.bfccqioarea1.com/</p>
SHIP	<p>State Health Insurance Assistance Program (SHIP) P.O. Box 191179, San Juan, PR 00919-1179 1-877-725-4300 (toll free/llamada gratuita) 1-787-721-6121 (local) 1-787-919-7291 (TTY) https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx</p>
SMO	<p>Administración de Seguros de Salud (ASES) P.O. Box 70184, San Juan, PR 00936-8184 1-787-641-4224 (local and toll free/llamada y línea gratuita) 1-787-625-6955 (TTY) 1-787-250-0990 (fax) www.medicaid.pr.gov</p>
SPAP	Not Applicable/No corresponde
ADAP	<p>Puerto Rico AIDS Drug, Copays and Coinsurance Assistance Program Departamento de Salud OCASET Programa Ryan White Parte B P.O. Box 70184, San Juan, PR 00936-8184 1-787-765-2929 1-787-766-7015 (fax) www.salud.gov.pr/Dept-de-Salud/Pages/Unidades-Operacionales/Secretaria-Auxiliar-de-Salud-Familiar-y-Servicios-Integrados/Division%20Central%20de%20Asuntos%20de%20SIDA%20y%20Enfermedades%20Transmisibles/Programa-Ryan-White.aspx</p>
RHODE ISLAND	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)</p>
SHIP	<p>Senior Health Insurance Program (SHIP) Rhode Island Department of Human Services, Division of Elderly Affairs 57 Howard Ave, Louis Pasteur Bldg. 2nd Floor, Cranston, RI 02920 1-888-884-8721 (local) 1-401-462-0740 (TTY) www.dea.ri.gov/</p>

Exhibit A: State Agency Contact Information

SMO	Executive Office of Health and Human Services Louis Pasteur Building, 57 Howard Avenue, Cranston, RI 02920 1-401-462-5274 (local) 1-855-697-4347 (toll free) 1-800-745-5555 (TTY) http://www.ohhs.ri.gov/contact/
SPAP	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) Attn: RIPAE, Rhode Island Department of Elderly Affairs 74 West Road 2nd Floor, Hazard Building, Cranston, RI 02920 1-401-462-3000 (local) 1-401-462-0740 (local) 1-401-462-0740 (TTY) http://www.oha.ri.gov/
ADAP	Rhode Island AIDS Drug Assistance Program (ADAP) Executive Office of Health & Human Services, Virks Building 3 West Road, Suite 227, Cranston, RI 02920 1-401-462-3295 1-401-462-3297 (fax) www.health.ri.gov/diseases/hiv aids/about/staying healthy/
SOUTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street, Suite 350, Columbia, SC 29201 1-800-868-9095 (toll free) 1-803-734-9900 (local) 1-803-734-9886 (fax) https://aging.sc.gov/
SMO	South Carolina Department of Health and Human Services (Medicaid) P.O. Box 8206, Columbia, SC 29202-8206 1-888-549-0820 (toll free) 1-803-898-2500 (local) 1-888-842-3620 (TTY) www.scdhhs.gov
SPAP	Not Applicable
ADAP	South Carolina AIDS Drug Assistance Program (ADAP) SC Drug Assistance Program/Direct Dispensing Program 3rd Floor, Mills Jarrett Box 101106, Columbia, SC 29211 1-800-856-9954 (toll free) http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HI VandSTDs/AIDSDrugAssistancePlan

2022 Evidence of Coverage for Humana Group Medicare Advantage PPO Plan
Exhibit A: State Agency Contact Information

SOUTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Information and Insurance Education (SHIINE) 2300 W. 46th St., Sioux Falls, SD 57105 1-800-536-8197 (toll free) 1-605-336-7471 (fax) www.shiine.net
SMO	Department of Social Services of South Dakota 700 Governors Drive, Richard F. Kneip Bldg., Pierre, SD 57501-2291 1-800-597-1603 (toll free) 1-605-773-3165 (local) 1-800-305-9673 (Spanish) https://dss.sd.gov/
SPAP	Not Applicable
ADAP	South Dakota AIDS Drug Assistance Program (ADAP) Ryan White Part B CARE Program South Dakota Department of Health 615 E. 4th St., Pierre, SD 57501-1700 1-800-592-1861 1-605-773-5509 (fax) 1-605-773-3737 https://doh.sd.gov/diseases/infectious/ryanwhite
TENNESSEE	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Tennessee Commission on Aging & Disability -TN SHIP 502 Deaderick St, 9th Floor, Nashville, TN 37243-0860 1-877-801-0044 (toll free) 1-615-741-2056 (local) 1-800 848-0299 (toll free TDD) http://tnmedicarehelp.com/%20or%20http://www.tn.gov/aging/
SMO	TennCare (Medicaid) 310 Great Circle Road, Nashville, TN 37243 1-800-342-3145 (toll free) 1-877-779-3103 (toll free TTY) 1-855-259-0701 (Spanish) 1-615-532-7322 (fax) www.tn.gov/tenncare/
SPAP	Not Applicable
ADAP	Tennessee HIV Drug Assistance Program (HDAP) TN Department of Health, HIV/STD Program, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243 1-615-741-7500 1-800-525-2437 (toll free) www.tn.gov/health

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Exhibit A: State Agency Contact Information

TEXAS	
QIO	<p>KEPRO 5201 W. Kennedy Dr., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776(TTY) 1-833-868-4060 (fax)</p>
SHIP	<p>Texas Department of Aging and Disability Services (HICAP) 1100 West 49th Street, Austin, TX 78756-3199 1-800-252-9240 (toll free) 1-800-735-2989 (toll free TTY) https://hhs.texas.gov/services/health/medicare</p>
SMO	<p>Texas Health and Human Services Commission (HHSC) Medicaid Program 4900 N. Lamar Blvd., Austin, TX 78751-2316 1-800-252-8263 (toll free) 1-512-424-6500 (local) 1-512-424-6597 (TTY) http://www.hhsc.state.tx.us</p>
SPAP	<p>Texas Kidney Health Care Program (KHC) Department of State Health Services MC 1938 P.O. Box 149347, Austin, TX 78714 1-800-222-3986 (toll free) 1-512-776-7150 (local) http://www.dshs.state.tx.us/kidney/default.shtm</p>
ADAP	<p>Texas AIDS Drug Assistance Program (ADAP) Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O Box 149347, Austin, TX 78714 1-800-255-1090 (toll free) 1-512-533-3178 (fax) http://www.dshs.state.tx.us/hivstd/default.shtm</p>
UTAH	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)</p>
SHIP	<p>Senior Health Insurance Information Program (SHIP) 195 North 1950 West, Salt Lake City, UT 84116 1-800-541-7735 (toll free) 1-801-538-3910 (local) 1-801-538-4395 (fax) https://daas.utah.gov/seniors/</p>
SMO	<p>Utah Department of Health Medicaid Martha S. Hughes Cannon Building 288 North 1460 West, Salt Lake City, UT 84116 1-800-662-9651 (toll free) 1-801-538-6155 (local) 1-866-608-9422 (Spanish) 1-801-538-6805 (fax) https://medicaid.utah.gov/</p>
SPAP	Not Applicable

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ADAP	Utah AIDS Drug Assistance Program (ADAP) Utah Department of Health Bureau of Epidemiology 288 North 1460 West Box 142104, Salt Lake City, UT 84114-2104 1-801-538-6191 1-801-538-9913 (fax) http://health.utah.gov
VERMONT	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 476 Main Street Suite #3, Winooski VT 05404 1-800-642-5119 (toll free) 1-(802) 865-0360 (local) www.vermont4a.org/
SMO	Agency of Human Services of Vermont Center Building 280 State Drive, Waterbury, VT 05671 1-800-250-8427 (toll free) 1-802-871-3008 (local) 1-802-879-5962 (fax) www.humanservices.vermont.gov/
SPAP	VPharm 312 Hurricane Lane, Suite 201, Williston, VT 05495 1-800-250-8427 (toll free) www.greenmountaincare.org/prescription
ADAP	Vermont Medication Assistance Program (VMAP) Vermont Department of Health, Vermont Medication Assistance Program 108 Cherry Street- PO BOX 70, Burlington, VT 05402 1-802-951-4005 1-802-863-7314 www.healthvermont.gov/prevent/aids/aids_index.aspx
VIRGINIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue, Suite 100, Henrico, VA 23229 1-800-552-3402 (toll free) 1-804-662-9333 (local) 1-804-552-3402 (toll free TTY) www.vda.virginia.gov
SMO	Department of Medical Assistance Services 600 East Broad Street, Suite 1300, Richmond, VA 23219 1-804-786-7933 (local) 1-855-242-8282 (toll free) 1-888-221-1590 (TTY) www.dmas.virginia.gov/

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Exhibit A: State Agency Contact Information

SPAP	<p>Virginia HIV SPAP HCS Unit, 1st Floor James Madison Building 109 Governor Street, Richmond, VA 23219 1-855-362-0658 (toll free) http://166.67.66.226/epidemiology/DiseasePrevention/Programs/ADAP/</p>
ADAP	<p>Virginia AIDS Drug Assistance Program (ADAP) Virginia Department of Health, HCS Unit, James Madison Building 1st Floor, 109 Governor Street, Richmond, VA 23219 1-855-362-0658 1-804-864-8050 www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/forms.htm</p>
WASHINGTON	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)</p>
SHIP	<p>Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255, Olympia, WA 98504-0255 1-800-562-6900 (toll free) 1-360-586-0241 (TTY) www.insurance.wa.gov/shiba</p>
SMO	<p>Washington State Health Care Authority (Medicaid) Cherry Street Plaza 626 8th Avenue SE, P.O. Box 45531, Olympia, WA 98501 1-800-562-3022 (toll free) www.hca.wa.gov/</p>
SPAP	Not Applicable
ADAP	<p>Washington State AIDS Drug Assistance Program (ADAP) Early Intervention Program (EIP) Client Services, P.O. Box 47841, Olympia, WA 98504 1-877-376-9316 (in Washington state) 1-360-664-2216 (fax) 1-360-236-3426 http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP</p>
WEST VIRGINIA	
QIO	<p>Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)</p>

Exhibit A: State Agency Contact Information

SHIP	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, Charleston, WV 25305 1-877-987-4463 (toll free) 1-304-558-3317 (local) 1-304-558-0004 (fax) www.wvship.org
SMO	West Virginia Department of Health & Human Resources Medicaid 350 Capitol Street, Room 251, Charleston, WV 25301-3709 1-800-642-8589 (toll free) 1-304-558-1700 (local) www.dhhr.wv.gov/bms
SPAP	Not Applicable
ADAP	West Virginia AIDS Drug Assistance Program (ADAP) Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003 1-304-232-6822 http://oeeps.wv.gov/rwp/pages/default.aspx
WISCONSIN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	WI State Health Ins. Assist. Program (SHIP) 1 West Wilson Street, Madison, WI 53703 1-800-242-1060 (toll free) 711 or 1-800-947-3529 (TTY) www.dhs.wisconsin.gov/benefit-specialists/ship.htm
SMO	Wisconsin Department of Health Services 1 West Wilson Street, Madison, WI 53703 3445 1-800-362-3002 (toll free) 1-608-266-1865 (local) 1-800-947-3529 (TTY) www.dhs.wisconsin.gov
SPAP	Wisconsin SeniorCare P.O. Box 6710, Madison, WI 53716 1-800-657-2038 (toll free) www.dhs.wisconsin.gov/seniorcare/
ADAP	Wisconsin AIDS Drug Assistance Program (ADAP) Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701 1-800-991-5532 1-608-266-1288 (fax) 1-608-267-6875 www.dhs.wisconsin.gov/aids-hiv/resources/overviews/AIDS_HIV_drug_reim.htm

Exhibit A: State Agency Contact Information

WYOMING	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 (toll free) 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams, Riverton, WY 82501 1-800-856-4398 (toll free) 1-307-856-6880 (local) www.wyomingseniors.com
SMO	Wyoming Department of Health 2300 Capital Ave, Suite 401, Hathaway Bldg., Cheyenne, WY 82002 1-866-571-0944 (toll free) 1-307-777-7656 (local) 1-307-777-7439 (fax) www.health.wyo.gov/
SPAP	Not Applicable
ADAP	Wyoming AIDS Drug Assistance Program (ADAP) Wyoming Department of Health, Communicable Disease Unit 6101 Yellowstone Rd. Suite 510, Cheyenne, WY 82002 1-307-777-5856 1-307-777-5279 www.health.wyo.gov/publichealth/communicable-disease-unit/hivaids/

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **1-800-733-9064** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **<https://www.hhs.gov/ocr/office/file/index.html>**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-800-733-9064 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-800-733-9064 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wóda'í beésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك