Your 2024 Evidence of Coverage

Humana®

Thanks for being a Humana Gold Choice H8145-042 (PFFS) member. We value your membership, and we're dedicated to helping you be the best you want to be.

This Evidence of Coverage contains important information about your plan. This book is a very detailed document with the full, legal description of your benefits and costs. You should keep this document for reference throughout the plan year.

Humana cares about your well-being

We look forward to being your partner in health for many years to come. If you have any questions, we're here to help.

2024
Evidence of Coverage

Humana Gold Choice
H8145-042 (PFFS)

Multi-Market VA
Select Counties in Virginia

Humana®

January 1 - December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Humana Gold Choice H8145-042 (PFFS)

This document gives you the details about your Medicare health care coverage from January 1 - December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-800-457-4708. (TTY users should call 711). Hours are from 8 a.m. to 8 p.m. seven days a week from Oct. 1 - Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30. This call is free.

This plan, Humana Gold Choice H8145-042 (PFFS), is offered by Humana Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means Humana Gold Choice H8145-042 (PFFS).)

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 at the number listed above if you need plan information in another format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage
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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Humana Gold Choice H8145-042 (PFFS), which is a Medicare Private Fee-for-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Humana Gold Choice H8145-042 (PFFS). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Humana Gold Choice H8145-042 (PFFS) is a Medicare Advantage Private-Fee-for-Service (PFFS) Plan. This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PFFS plan is approved by Medicare and run by a private company.

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 on the individual requirement for QHC.

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

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Humana Gold Choice H8145-042 (PFFS).

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* document.

If you are confused, concerned, or just have a question, please contact Customer Care.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Humana Gold Choice H8145-042 (PFFS) 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 Gold Choice H8145-042 (PFFS) between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Humana Gold Choice H8145-042 (PFFS) after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Humana Gold Choice H8145-042 (PFFS) each year. You can continue each year 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
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for Humana Gold Choice H8145-042 (PFFS)

Humana Gold Choice H8145-042 (PFFS) 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.

Our service area includes the following county/counties in Virginia: Bedford, Bland, Botetourt, Brunswick, Buckingham, Carroll, Chesapeake City, Chesterfield, Craig, Emporia City, Essex, Floyd, Galax City, Giles, Gloucester, Goochland, Greensville, Hampton City, Hanover, Henrico, Isle of Wight, Lancaster, Middlesex, Newport News City, Norfolk City, Northumberland, Nottoway, Orange, Patrick, Petersburg City, Portsmouth City, Powhatan, Prince Edward, Radford City, Richmond, Richmond City, Roanoke, Roanoke City, Salem City, Southampton, Suffolk City, Virginia Beach City, Williamsburg City, York Counties, VA.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Care to see if we have a plan in your new area. 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.

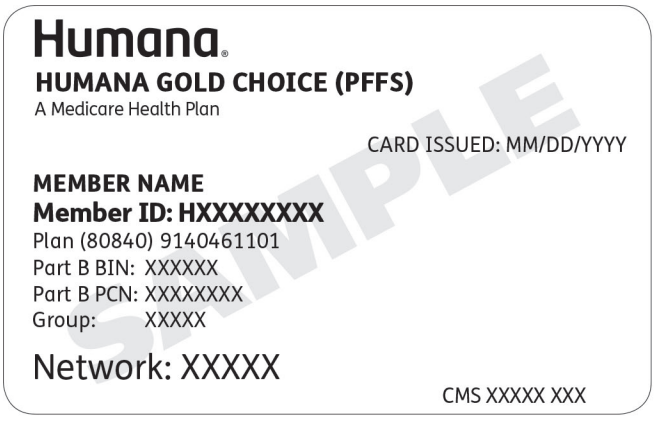
Section 2.3 U.S. Citizen or Lawful Presence

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 Gold Choice H8145-042 (PFFS) if you are not eligible to remain a member on this basis. Humana Gold Choice H8145-042 (PFFS) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get 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:



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 Gold Choice H8145-042 (PFFS) membership card, you may have to pay the full cost of medical 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 Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities we have agreements with to deliver covered services to members in our plan. These providers have already agreed to see members of our plan. See Chapter 3, Section 1.2 for information about the rules for getting your covered services under our plan.

We have network providers for all services covered under Original Medicare. You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described in Chapter 3, Section 1.2.

There are several reasons why it is important for you to know whether our plan uses a network and if so, which providers are part of the plan's network:

- A network provider must furnish you care while an out-of-network provider has the right to refuse to treat you.

- A network provider will charge less cost-sharing than an out-of-network provider. The amount of cost-sharing you pay a provider who is not one of our network providers may be more than the cost-sharing you pay a network provider. In the plan's Medical Benefits Chart in Chapter 4 of this document, we indicate the services for which the cost-sharing amount differs between network providers and out-of-network providers.
- Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. Chapter 7 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.
- In our plan's network, we must provide a sufficient number and range of providers to meet your needs.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Care. Requests for hard copy Provider Directories will be mailed to you within three business days. You can also see the find this information on our website at **Humana.com/PlanDocuments** The website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly costs for Humana Gold Choice H8145-042 (PFFS)

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Section 4.1 Plan Premium

You do not pay a separate monthly plan premium for Humana Gold Choice H8145-042 (PFFS).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called optional supplemental benefits, then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

MyOption DEN478: **$46.40** additional monthly premium

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, 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 or domestic partner'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 (**Note:** You are not required to tell your plan about the clinical research studies, you intend to participate in, but we encourage you to do so)

If any of this information changes, please let us know by calling Customer Care.

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.

SECTION 7 How other insurance works with our plan

Other insurance

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. This is called **Coordination of Benefits**.

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. 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.

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. If you have other insurance, tell your doctor, hospital, and pharmacy.

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 or domestic partner 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.

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.

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Humana Gold Choice H8145-042 (PFFS) contacts
(how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care

For assistance with claims, billing, or member card questions, please call or write to Humana Gold Choice H8145-042 (PFFS) Customer Care. We will be happy to help you.

Method	Customer Care – Contact Information
CALL	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 to September 30. 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. Hours of operation are the same as above.
FAX	1-877-837-7741
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com/customer-support** Live chat available through **Humana.com**, Monday through Friday, 8 a.m. to 8 p.m., Eastern Standard Time.

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

Method	Coverage Decisions For Medical Care – Contact Information
CALL	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 to September 30. For fast (expedited) coverage decisions, call 1-866-737-5113.

Method	Coverage Decisions For Medical Care – Contact Information
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. Hours of operation are the same as above.
FAX	1-888-200-7440 for expedited coverage decisions only
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com/medicare-support/member-guidelines/exceptions-and-appeals** Live chat available through **Humana.com**, Monday through Friday, 8 a.m. to 8 p.m., Eastern Standard Time.

Method	Appeals For Medical Care – Contact Information
CALL	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. For expedited appeals please call 1-800-867-6601.
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. Hours of operation are the same as above.
FAX	1-888-556-2128
WRITE	Humana Grievances and Appeals Dept. P.O. Box 14165 Lexington, KY 40512-4165
WEBSITE	**Humana.com/denial** Live chat available through **Humana.com**, Monday through Friday, 8 a.m. to 8 p.m., Eastern Standard Time.

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. 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	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. For expedited grievances please call 1-800-867-6601.
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. Hours of operation are the same as above.
FAX	1-888-556-2128
WRITE	Humana Grievances and Appeals Dept. P.O. Box 14165 Lexington, KY 40512-4165
MEDICARE WEBSITE	You can submit a complaint about Humana Gold Choice H8145-042 (PFFS) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. 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	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 to September 30.
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. Hours of operation are the same as above.
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168

Method	Payment Requests – Contact Information
WEBSITE	**Humana.com** Live chat available through **Humana.com**, Monday through Friday, 8 a.m. to 8 p.m., Eastern Standard Time.

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.
WEBSITE	www.medicare.gov 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 documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **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 *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Humana Gold Choice H8145-042 (PFFS):

Method	Medicare – Contact Information
WEBSITE (continued)	• **Tell Medicare about your complaint:** You can submit a complaint about Humana Gold Choice H8145-042 (PFFS) 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 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 and review the information with 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.)

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

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

SHIP counselors 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. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in the middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Contact information for your state Quality Improvement Organization (QIO) can be found in "Exhibit A" in the back of this document.

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

You should contact your 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.

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 8:00 am to 7:00 pm, 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 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

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. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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 document.

What is the AIDS Drug Assistance Program (ADAP)? What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the ADAP operating in your State.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP operating in your State. Contact information for your AIDS Drug Assistance Program (ADAP) can be found in “Exhibit A” in the back of this document.

SECTION 7 How to contact the Railroad Retirement Board

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

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.

Method	Railroad Retirement Board – Contact Information
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 *not* free.
WEBSITE	rrb.gov/

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner'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 or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this document.) 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 for your medical services

SECTION 1 Things to know about getting your medical care 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, equipment, 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?

- **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. Section 1.2 describes the rules for getting covered services using our network providers.
- **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 Gold Choice H8145-042 (PFFS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Humana Gold Choice H8145-042 (PFFS) 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 document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider in the United States who (1) agrees to accept our plan's terms and conditions of payment prior to providing services to you and (2) is eligible to provide services under Original Medicare** or eligible to be paid by Humana Gold Choice H8145-042 (PFFS) for benefits that are not covered under Original Medicare.

You are in a full network PFFS plan

- We have a network of providers (that is, providers who have agreements with our plan) for all services covered under Original Medicare. These providers have already agreed to see members of our plan.
- You can still receive covered services from out-of-network providers (those who do not have an agreement with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described earlier in this section.
- If your provider is not one of our network providers, then the provider is not required to accept the plan's terms and conditions of payment and they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider who will accept our terms and conditions of payment.
- Providers can find the plan's terms and conditions of payment on our website at: **https://www.humana.com/medicare/medicare-advantage-plans/humana-choice-pffs**
- A provider is considered to have agreed to accept the terms and conditions of payment if the provider was aware that you are a member of Humana Gold Choice H8145-042 (PFFS) before providing services to you (for example: if you showed them your plan membership card); the provider had reasonable access to our terms and conditions of payment; and the provider provided covered services to you. The provider doesn't have to actually read the terms and conditions of payment - If the provider had the opportunity to read them and treats you, the law deems this provider to have agreed to accept our plan's terms and conditions of payment for that specific visit.
  - > You must show your plan membership card every time you visit a provider. A provider can decide at every visit whether to accept our plan's terms and conditions, and thus treat you. After accepting the terms and conditions of payment, a provider cannot change their mind and charge you more than your plan cost sharing.
- If you need emergency care, it is covered whether a provider agrees to accept the plan's payment terms or not.
- Our plan has agreements with some providers to deliver covered services to members in our plan. These providers are our network providers. If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Care.
- We have network providers for all services covered under Original Medicare as well as other services not covered by Original Medicare. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described earlier in this section.

- **You are required to pay only the copayment or coinsurance amount allowed by our plan at the time of the visit.** You should ask the provider to bill the plan for your covered services. If a provider asks you to pay the full amount of the services, then send the bill or a copy of the bill to us to pay you back, remind the provider that you are only responsible for the cost-sharing amount. If the provider wants further information on payment for covered services, please have the provider contact us at 1-866-777-1569, TTY 1-800-833-3302. Humana, P. O. Box 14168, Lexington, KY 40512-4168.
- Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore,

will be paid for by our plan. Chapter 7 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.

- Humana Gold Choice H8145-042 (PFFS) does not require members or their providers to obtain prior authorization or a referral from the plan as a condition for covering medically necessary services that are covered by our plan. 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.

SECTION 2 Using providers in the plan's network to get your medical care

Section 2.1 How to get care from network providers

We encourage you to select a doctor to act as your Primary Care Provider (PCP). A PCP can focus on your needs and coordinate your care with other providers when needed. Your PCP can check or consult with other network providers about your care and how it's going.

We list providers who participate with our plan in our *Provider Directory*. While you're a member of our plan, you can use either network providers or out-of-network providers. However, your out-of-pocket costs may be higher with out-of-network providers, except for emergency care or out-of-network dialysis services. See Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) for details on your costs.

You don't need to get a referral or prior authorization when you get care for covered services. However, before getting services, you may want to confirm with us that we cover the services and that they're medically necessary.

If an out-of-network provider sends you a bill 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*). This explains how to ask us to pay that bill for you. We'll pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay an out-of-network provider more than if you had been covered with Original Medicare.

It's best to ask an out-of-network provider to bill us first. But if you've already paid for the covered services, we'll pay you for our share of the cost. (Please note that we can't pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm they haven't opted out of Medicare.) If we later determine the services aren't covered or weren't medically necessary, we may deny coverage. If this happens, you'll have to pay the entire cost.

What if a 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. If your doctor or specialist leaves 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 notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- 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.
- 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 a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Contact Customer Care at 1-800-457-4708, TTY 711 for assistance with selecting a new qualified provider to continue managing your health care needs.

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 believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. 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 from our plan. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **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 Customer Care using the phone number printed on the back cover of this document.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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 doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

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.

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

What are urgently needed services?

An urgently needed service is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by network providers or by out of-network providers when network providers are temporarily unavailable or inaccessible.

What providers should you use when you have an urgent need for care?

We cover urgently needed services you receive from a network provider or from any out-of-network provider who is willing to furnish services as a deemed provider.

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

The plan's *Provider Directory* will tell you which facilities in your area are in-network. This information can also be found online at **Humana.com/findadoctor**. For any other questions regarding urgently needed services, please contact Customer Care.

What if you are <u>outside</u> 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. Our plan does not cover urgently needed services or any other non-emergency care if you receive the care outside of the United States.

Our plan covers worldwide emergency and urgent care services outside of the United States under the following circumstances. If you have an emergency or an urgent need for care outside of the U.S. and its territories, you will be responsible to pay for those services upfront and request appropriate reimbursement from us. We will reimburse you for covered out-of-network emergency and urgent care services outside of the U.S. and its territories; however, the reimbursement rates will be no greater than the rates at which Original Medicare would pay for such services had the services been performed in the United States in the locality where you reside. The amount we pay you, if any, will be reduced by any applicable cost-sharing. Because we will reimburse at rates no greater than the rates at which Original Medicare would reimburse, and because foreign providers might charge more for services than the rates at which Original Medicare would pay, the total of our reimbursement plus the applicable cost-sharing may be less than the amounts you pay the foreign provider. This is a supplemental benefit not generally covered by Medicare. You must submit proof of payment to Humana for reimbursement. 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 with medical records to us for payment consideration. 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 3.3 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: **Humana.com/alert** for information on how to obtain needed care during a disaster.

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 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 plan cost-sharing 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 Gold Choice H8145-042 (PFFS) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan.

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.

For covered services that have a benefit limitation, you also 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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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,and you express interest, 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. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. 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 any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. 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. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare or our plan has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the 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.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network 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. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how 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 you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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 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 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. This benefit is provided only for Part A inpatient services (non-medical health care services).

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.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - *and* – you must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in Chapter 4).

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 oxygen equipment and supplies, 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 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 Gold Choice H8145-042 (PFFS), 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, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Care for more information.

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. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will

have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section.7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Humana Gold Choice H8145-042 (PFFS) 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 Gold Choice H8145-042 (PFFS) or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

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

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

This chapter provides 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 Gold Choice H8145-042 (PFFS). Later in this chapter, you can find information about medical services that are not covered. Also, see exclusions and limitations pertaining to certain supplemental benefits in the chart in this chapter.

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.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- **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.)
- **Balance billing** is when providers, such as doctors or hospitals, charge and bill patients up to 15% more than the plan's payment amount for services. The balance billing amount is collected in addition to the patient's regular plan cost-sharing amount. Humana Gold Choice H8145-042 (PFFS) does not allow providers who provide plan-covered services to balance bill members of our plan. (For more information, see Section 1.4 of this chapter.)

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.

Section 1.2 What is your plan deductible?

Your deductible is **$750** for out-of-network services. Until you have paid the deductible amount, you must pay the full cost of your covered services from out-of-network providers. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services from out-of-network providers and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The out-of-network deductible does not apply to the following services:

- Ambulance Services
- Diabetic Monitoring Supplies

- Chemotherapy Drugs and Administration
- Medicare Part B Covered Drugs
- Emergency Room Services
- Urgently Needed Services at Urgent Care Centers
- Immunizations (Flu & Pneumonia)
- Supplemental Benefits
  - Supplemental benefits covered by the plan are described in the Medical Benefits Chart within this chapter, Section 2. Benefits are identified with an asterisk (*).

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is **$7,550**.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of and **$7,550**, you will not have to pay any out-of-pocket costs for the rest of the 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 How does balance billing affect your costs?

Our plan does not allow balance billing. This means a provider is allowed to collect only the plan cost-sharing amounts from you and is not allowed to charge or bill you more for services. Balance billing is prohibited by providers who provide plan-covered services to Humana Gold Choice H8145-042 (PFFS) members.

There is an additional type of balance billing that physicians who do not participate with Medicare and who are not in the plan's network have a right to collect. However, you will never have to pay this type of balance billing. The provider will collect this balance billing amount from us and you will only pay your cost-sharing amount. If you have any questions about how much you would have to pay a provider, please contact Customer Care.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered 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 Gold Choice H8145-042 (PFFS) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5.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, equipment, and Part B prescription drugs) *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.
- No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are provided to our members.

Other important things to know about our coverage:

- 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 2024* 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. 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.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the Medical Benefits Chart.

*** You will see this asterisk next to the supplemental benefits in the Medical Benefits Chart.**

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening 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	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive

Services that are covered for you	What you must pay when you get these services
nurse specialist.	screening. **Out-of-Network:** **$0** copayment – Specialist's Office – Freestanding Radiological Facility – Outpatient Hospital
Acupuncture for chronic low back pain Covered services include: Up to 20 visits per year for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. Prior authorization requirements may apply.	**In-Network:** **20%** coinsurance – Specialist's Office **Out-of-Network:** **40%** coinsurance – Specialist's Office
Allergy shots and serum You are covered for allergy shots and serum when medically necessary.	**In-Network:** **$0** copayment – PCP's Office – Specialist's Office **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, 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. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could	**In-Network:** Emergency Ambulance **$300** copayment per date of service regardless of the number of trips – Ground Ambulance – Air Ambulance Non-Emergency Ambulance **$300** copayment per date of

Services that are covered for you	What you must pay when you get these services
endanger the person's health and that transportation by ambulance is medically required.	service regardless of the number of trips – Ground Ambulance – Air Ambulance **Out-of-Network:** Emergency Ambulance **$300** copayment per date of service regardless of the number of trips – Ground Ambulance – Air Ambulance Non-Emergency Ambulance **$300** copayment per date of service regardless of the number of trips – Ground Ambulance – Air Ambulance
Annual wellness visit 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. **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.	**In-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network:** **$0** copayment – PCP's Office
Bone mass measurement 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.	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network:** **$0** copayment – Specialist's Office – Freestanding Radiological Facility – Outpatient Hospital
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	What you must pay when you get these services
• One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**Out-of-Network:** **$0** copayment – Specialist's Office – Freestanding Radiological Facility – Outpatient Hospital
Cardiac rehabilitation services 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.	**In-Network:** **$15** copayment – Specialist's Office – Outpatient Hospital **Out-of-Network:** **$15** copayment – Specialist's Office – Outpatient Hospital
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) 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.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network:** **$0** copayment – PCP's Office
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office – Freestanding Laboratory – Outpatient Hospital
Cervical and vaginal cancer screening Covered services include: • 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	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network:** **$0** copayment

Services that are covered for you	What you must pay when you get these services
	– PCP's Office – Specialist's Office
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation • Other services performed by a chiropractor are not covered	**In-Network:** Medicare Covered Chiropractic Services **$15** copayment – Specialist's Office **Out-of-Network:** Medicare Covered Chiropractic Services **$15** copayment – Specialist's Office
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **Out-of-Network:** **$0** copayment – Specialist's Office – Ambulatory Surgical Center – Outpatient Hospital
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However,	**In-Network:** Medicare Covered Dental Services **$50** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: • Medically necessary dental services, as covered by Original Medicare	**Out-of-Network:** Medicare Covered Dental Services **$50** copayment – Specialist's Office **Supplemental dental benefits** *You are covered for supplemental dental benefits. See the supplemental dental benefit description at the end of this chart for details.
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.	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network:** **$0** copayment – PCP's Office
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.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office – Freestanding Laboratory – Outpatient Hospital
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • 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. – These are the only covered (preferred) 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	**In-Network:** Diabetes self-management training **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital Diabetic Monitoring Supplies **$0** copayment – Preferred Diabetic Supplier **20%** coinsurance – Diabetic Supplier **10%** coinsurance

Services that are covered for you	What you must pay when you get these services
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 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. • Diabetes self-management training is covered under certain conditions • For Continuous Glucose Monitors, see Durable medical equipment (DME) and related supplies. The (preventive service) only applies to Diabetes self-management training.	– Network Retail Pharmacy Diabetic Shoes and Inserts **$10** copayment – Durable Medical Equipment Provider – Prosthetics Provider **Out-of-Network:** Diabetes self-management training **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital Diabetic Monitoring Supplies **20%** coinsurance – Diabetic Supplier **10%** coinsurance – Pharmacy Diabetic Shoes and Inserts **$10** copayment – Durable Medical Equipment Provider – Prosthetics Provider
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: 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, continuous glucose monitors**, and walkers. 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 **Humana.com/findadoctor**. **Preferred Continuous Glucose Monitors (CGMs) are available at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not available through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically	**In-Network:** Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider **Out-of-Network:** Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider

Services that are covered for you	What you must pay when you get these services
necessary. All CGMs will continue to be available through durable medical equipment providers (DME).	
EKG screening The screening EKG, when done as a referral from the Welcome to Medicare preventative visit, is only covered once during a beneficiary's lifetime.	**In-Network:** There is no coinsurance, copayment, or deductible for an EKG screening visit. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 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 (and, if you are a pregnant woman, loss of an unborn child), 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. You are covered for emergency care world-wide. 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.	**In-Network:** Emergency Services **$100** copayment – Emergency Room Provider and Professional Services **$0** copayment – Emergency Room **Out-of-Network:** Emergency Services **$100** copayment – Emergency Room Provider and Professional Services **$0** copayment – Emergency Room If you move into an observation status, your emergency care copay will be waived and you will pay your observation copay. For further information, see the Outpatient Observation section of this chart.
Hearing services 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.	**In-Network:** Medicare Covered Hearing Services **$50** copayment – Specialist's Office **Out-of-Network:** Medicare Covered Hearing Services **$50** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
	Supplemental hearing benefits *You are covered for supplemental hearing benefits. See the supplemental hearing benefit description at the end of this chart for details.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Freestanding Laboratory
Home health agency care 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. Covered services include, but are not limited to: • 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	**In-Network:** Home Health Care **$0** copayment – Member's Home Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider **Out-of-Network:** Home Health Care **$0** copayment – Member's Home Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider
Home infusion therapy 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	**In-Network:** Medical Supplies **20%** coinsurance – Medical Supply Provider Medicare Part B Covered Drugs **20%** coinsurance

Services that are covered for you	What you must pay when you get these services
example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • 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 Prior authorization requirements may apply.	– PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Provider and Professional Services **$0** copayment – PCP's Office **Out-of-Network:** Medical Supplies **20%** coinsurance – Medical Supply Provider Medicare Part B Covered Drugs **20%** coinsurance – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Provider and Professional Services **$0** copayment – PCP's Office
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider 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	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 Gold Choice H8145-042 (PFFS). Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. Provider cost sharing may apply for outpatient consultations.

Services that are covered for you	What you must pay when you get these services
the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: 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 and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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 For services that are covered by Humana Gold Choice H8145-042 (PFFS) but are not covered by Medicare Part A or B: Humana Gold Choice H8145-042 (PFFS) 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. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
*** Hospital services in the home: Provider referred** You may be referred to one of Humana's contracted in-home care providers by your provider to receive the following non-Medicare covered hospital services in your home. Hospital services in the home allows for certain health care services to be provided outside of a traditional hospital setting and within your home. Care begins after you're evaluated, determined to be eligible, and your provider refers you. Your provider will consider your eligibility criteria including your medical conditions and your geographic location. No emergency room or inpatient visit is required to begin treatment. You will receive treatment and monitoring at home from a team of providers for up to 30 day episode of care. Conditions which are eligible to be treated with this benefit can include: asthma, congestive heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), nutritional/metabolic disorders and urinary tract infections (UTI). Prior authorization requirements may apply.	**$0** copayment
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine	**In-Network:** There is no coinsurance, copayment, or deductible for the

Services that are covered for you	What you must pay when you get these services
• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office
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. You are covered for an unlimited number of medically necessary inpatient hospital days. Covered services include but are not limited to: • 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 • 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. – If you are in need of a solid organ or bone marrow/stem cell transplant, please contact our Transplant Department at 1-866-421-5663, TTY 711 for important information about your transplant care. • 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 **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.	Your inpatient cost share 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. **In-Network:** Inpatient Care Inpatient Hospital – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days 6 to 90 Provider and Professional Services **$0** copayment – Inpatient Hospital **Out-of-Network:** Inpatient Care Inpatient Hospital – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days 6 to 90 Provider and Professional Services **$0** copayment – Inpatient Hospital

Services that are covered for you	What you must pay when you get these services
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 https://www.medicare.gov/sites/default/files/2021-10/11435-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.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital – 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	Your inpatient cost share 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. **In-Network:** Inpatient Mental Health Care Inpatient Hospital – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days 6 to 90 Inpatient Psychiatric Facility – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days 6 to 90 Provider and Professional Services **$0** copayment – Inpatient Hospital – Inpatient Psychiatric Facility **Out-of-Network:** Inpatient Mental Health Care Inpatient Hospital – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days 6 to 90 Inpatient Psychiatric Facility – **$345** copayment per day, days 1 to 5 – **$0** copayment per day, days

Services that are covered for you	What you must pay when you get these services
	6 to 90 Provider and Professional Services **$0** copayment – Inpatient Hospital – Inpatient Psychiatric Facility
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay 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: • 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	When your inpatient stay is not covered, you will pay the cost of the services received as described throughout this benefit chart.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. 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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
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.	**Out-of-Network:** **$0** copayment – MDPP Supplier
Medicare Part B prescription drugs 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: • 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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other 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®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Humana.com/PAL We also cover some vaccines under our Part B prescription drug benefit. Prior authorization requirements may apply.	**In-Network:** Medicare Part B Covered Drugs **20%** coinsurance – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Chemotherapy Drugs **20%** coinsurance – Specialist's Office – Outpatient Hospital **Out-of-Network:** Medicare Part B Covered Drugs **20%** coinsurance – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Chemotherapy Drugs **20%** coinsurance – Specialist's Office – Outpatient Hospital Some rebatable Part B drugs may be subject to a lower coinsurance. There may be a cost for the administration of a Part B drug, in addition to the cost for the drug itself. You may have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." You will pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a

Services that are covered for you	What you must pay when you get these services
	deductible it does not apply to the Part B insulin.
*** NationsMarket® Fresh, Prepared Meal Program** After your inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 7 days at no extra cost to you. 14 freshly made meals will be delivered to your home. Meal program limited to 4 times per calendar year. Meals have to be requested within 30 days of discharge from inpatient stay. For additional information, please contact the number on the back of your Humana Member ID card. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 5.	**In-Network:** There is no coinsurance, copayment, or deductible to participate. **Out-of-Network** **50%** coinsurance
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.	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network:** **$0** copayment – PCP's Office
Opioid treatment program 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: • 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	**In-Network:** **$45** copayment – Specialist's Office **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization **Out-of-Network:** **$45** copayment – Specialist's Office **$100** copayment

Services that are covered for you	What you must pay when you get these services
	– Outpatient Hospital **$70** copayment – Partial Hospitalization
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Other outpatient diagnostic tests	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Diagnostic Procedures and Tests **$0** copayment – PCP's Office **$50** copayment – Specialist's Office – Urgent Care Center **$100** copayment – Outpatient Hospital Advanced Imaging Services **$200** copayment – PCP's Office – Specialist's Office – Freestanding Radiological Facility **$300** copayment – Outpatient Hospital Basic Radiological Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office – Urgent Care Center – Freestanding Radiological Facility **$125** copayment – Outpatient Hospital Diagnostic Mammography

Services that are covered for you	What you must pay when you get these services
	$50 copayment – Specialist's Office **$75** copayment – Outpatient Hospital – Freestanding Radiological Facility <u>Radiation Therapy</u> **$50** copayment – Specialist's Office **20%** coinsurance – Outpatient Hospital – Freestanding Radiological Facility <u>Nuclear Medicine Services</u> **$275** copayment – Outpatient Hospital – Freestanding Radiological Facility <u>Facility Based Sleep Study</u> **$50** copayment – Specialist's Office **$100** copayment – Outpatient Hospital <u>Home Based Sleep Study</u> **$0** copayment – Member's Home <u>Medical Supplies</u> **20%** coinsurance – Medical Supply Provider <u>Diagnostic Colonoscopy</u> **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital <u>Lab Services</u> **$0** copayment – PCP's Office – Specialist's Office

Services that are covered for you	What you must pay when you get these services
	– Freestanding Laboratory **$50** copayment – Urgent Care Center – Outpatient Hospital **Out-of-Network:** Provider and Professional Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Diagnostic Procedures and Tests **$0** copayment – PCP's Office **$50** copayment – Specialist's Office – Urgent Care Center **$100** copayment – Outpatient Hospital Advanced Imaging Services **$200** copayment – PCP's Office – Specialist's Office – Freestanding Radiological Facility **$300** copayment – Outpatient Hospital Basic Radiological Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office – Urgent Care Center – Freestanding Radiological Facility **$125** copayment – Outpatient Hospital

Services that are covered for you	What you must pay when you get these services
	Diagnostic Mammography **$50** copayment – Specialist's Office **$75** copayment – Outpatient Hospital – Freestanding Radiological Facility Radiation Therapy **$50** copayment – Specialist's Office **20%** coinsurance – Outpatient Hospital – Freestanding Radiological Facility Nuclear Medicine Services **$275** copayment – Outpatient Hospital – Freestanding Radiological Facility Facility Based Sleep Study **$50** copayment – Specialist's Office **$100** copayment – Outpatient Hospital Home Based Sleep Study **$0** copayment – Member's Home Medical Supplies **20%** coinsurance – Medical Supply Provider Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital Lab Services **$0** copayment – PCP's Office

Services that are covered for you	What you must pay when you get these services
	– Specialist's Office – Freestanding Laboratory **$50** copayment – Urgent Care Center – Outpatient Hospital
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. 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 https://www.medicare.gov/sites/default/files/2021-10/11435-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.	**In-Network:** **$350** copayment – Outpatient Hospital **Out-of-Network:** **$350** copayment – Outpatient Hospital
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts	**In-Network:** Diagnostic Procedures and Tests **$100** copayment – Outpatient Hospital Advanced Imaging Services **$300** copayment – Outpatient Hospital Nuclear Medicine Services **$275** copayment – Outpatient Hospital Basic Radiological Services **$125** copayment – Outpatient Hospital

Services that are covered for you	What you must pay when you get these services
for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. 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 https://www.medicare.gov/sites/default/files/2021-10/11435-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.	Diagnostic Mammography **$75** copayment – Outpatient Hospital Radiation Therapy **20%** coinsurance – Outpatient Hospital Lab Services **$50** copayment – Outpatient Hospital Surgery Services **$375** copayment – Outpatient Hospital Mental Health Services **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization Wound Care **$50** copayment – Outpatient Hospital Facility Based Sleep Study **$100** copayment – Outpatient Hospital Emergency Services **$100** copayment – Emergency Room Diagnostic Colonoscopy **$0** copayment – Outpatient Hospital **Out-of-Network:** Diagnostic Procedures and Tests **$100** copayment – Outpatient Hospital Advanced Imaging Services **$300** copayment – Outpatient Hospital

Services that are covered for you	What you must pay when you get these services
	Nuclear Medicine Services **$275** copayment – Outpatient Hospital Basic Radiological Services **$125** copayment – Outpatient Hospital Diagnostic Mammography **$75** copayment – Outpatient Hospital Radiation Therapy **20%** coinsurance – Outpatient Hospital Lab Services **$50** copayment – Outpatient Hospital Surgery Services **$375** copayment – Outpatient Hospital Mental Health Services **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization Wound Care **$50** copayment – Outpatient Hospital Facility Based Sleep Study **$100** copayment – Outpatient Hospital Emergency Services **$100** copayment – Emergency Room Diagnostic Colonoscopy **$0** copayment – Outpatient Hospital
Outpatient mental health care	**In-Network:**

Services that are covered for you	What you must pay when you get these services
Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	Mental Health Services **$45** copayment – Specialist's Office **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization **Out-of-Network:** Mental Health Services **$45** copayment – Specialist's Office **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network:** Physical Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital Speech Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital Occupational Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital

Services that are covered for you	What you must pay when you get these services
	Out-of-Network: Physical Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital Speech Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital Occupational Therapy **$15** copayment – Specialist's Office – Comprehensive Outpatient Rehab Facility **$40** copayment – Outpatient Hospital
Outpatient substance abuse services You are covered for treatment of substance abuse, as covered by Original Medicare.	**In-Network:** Substance Abuse Services **$45** copayment – Specialist's Office **$100** copayment – Outpatient Hospital **$70** copayment – Partial Hospitalization **Out-of-Network:** Substance Abuse Services **$45** copayment – Specialist's Office **$100** copayment – Outpatient Hospital **$70** copayment

Services that are covered for you	What you must pay when you get these services
	– Partial Hospitalization
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **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.	**In-Network:** Surgery Services **$375** copayment – Outpatient Hospital **$325** copayment – Ambulatory Surgical Center Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital **Out-of-Network:** Surgery Services **$375** copayment – Outpatient Hospital **$325** copayment – Ambulatory Surgical Center Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital
*** Over-the-Counter (OTC) Mail Order** You have a **$75** quarterly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider. • Quarterly allowance amounts are available to use at the beginning of January, April, July, and October. • Unused amount expires at the end of the quarter. • Limitations and restrictions may apply. Please contact Customer Care for additional benefit details or to obtain an order form. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share.	**In-Network:** **$0** copayment **Out-of-Network** **50%** coinsurance

Services that are covered for you	What you must pay when you get these services
When using an out-of-network provider you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 5.	
Partial hospitalization services and Intensive outpatient services 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. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	**In-Network:** **$70** copayment – Partial Hospitalization **Out-of-Network:** **$70** copayment – Partial Hospitalization
*** Physical exam (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: • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions **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.	**In-Network:** **$0** copayment – PCP's Office **Out-of-Network:** **$0** copayment – PCP's Office
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including services by primary care providers (PCPs) and specialists; individual sessions for mental health specialty services and psychiatric services; individual sessions for outpatient substance abuse; and urgently needed services – You have the option of getting these services 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 by telehealth – You may use a phone, computer, tablet, or other video technology	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Telehealth Services **$0** copayment – PCP Virtual – Mental Health Care and Substance Abuse Treatment Virtual **$50** copayment – Specialist Virtual – Urgent Care Virtual

Services that are covered for you	What you must pay when you get these services
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: – You're not a new patient **and** – The check-in isn't related to an office visit in the past 7 days **and** – The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: – You're not a new patient **and** – The evaluation isn't related to an office visit in the past 7 days **and** – The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to 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 of neoplastic cancer disease, or services that would be covered when provided by a physician) • Urgently needed services furnished in a physician's office	Advanced Imaging Services **$200** copayment – PCP's Office – Specialist's Office Surgery Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Radiation Therapy **$50** copayment – Specialist's Office Urgently Needed Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office **Out-of-Network:** Provider and Professional Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Advanced Imaging Services **$200** copayment – PCP's Office – Specialist's Office Surgery Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office Radiation Therapy **$50** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
	Urgently Needed Services **$0** copayment – PCP's Office **$50** copayment – Specialist's Office
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network:** Medicare Covered Podiatry Services **$50** copayment – Specialist's Office **Out-of-Network:** Medicare Covered Podiatry Services **$50** copayment – Specialist's Office
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and 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 detail.	**In-Network:** **20%** coinsurance – Prosthetics Provider **Out-of-Network:** **20%** coinsurance – Prosthetics Provider
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.	**In-Network:** **$15** copayment – Specialist's Office – Outpatient Hospital **Out-of-Network:** **$15** copayment – Specialist's Office – Outpatient Hospital
Screening and counseling to reduce alcohol misuse	**In-Network:**

Services that are covered for you	What you must pay when you get these services
We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network:** **$0** copayment – PCP's Office
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 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. *For LDCT lung cancer screenings after the initial LDCT screening:* 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 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.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT. **Out-of-Network:** **$0** copayment – Specialist's Office – Freestanding Radiological Facility – Outpatient Hospital
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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. We also cover up to two 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.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network:** **$0** copayment – PCP's Office
Services to treat kidney disease Covered services include:	**In-Network:** Kidney Disease Education Services **$0** copayment – PCP's Office

Services that are covered for you	What you must pay when you get these services
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) 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*.	– Specialist's Office Renal Dialysis Services **20%** coinsurance – Dialysis Center – Outpatient Hospital Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider Home Health Care **$0** copayment – Member's Home **Out-of-Network:** Kidney Disease Education Services **$0** copayment – PCP's Office – Specialist's Office Renal Dialysis Services **20%** coinsurance – Dialysis Center – Outpatient Hospital Durable Medical Equipment **20%** coinsurance – Durable Medical Equipment Provider Home Health Care **$0** copayment – Member's Home
*** SilverSneakers® Fitness program** SilverSneakers® is a fitness program for seniors that is included at no additional charge with qualifying Medicare health plans. Members have access to participating fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. Access online education on **SilverSneakers.com**, watch workout videos on SilverSneakers On-Demand™ or download the SilverSneakers GO™ fitness app for additional workout ideas.	**In-Network:** **$0** copayment

Services that are covered for you	What you must pay when you get these services
Any fitness center services that usually have an extra fee are not included in your membership.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. Covered services include but are not limited to: • 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 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	A new benefit period will begin on day one when you first enroll in a Medicare Advantage plan, or when you have been discharged from skilled care in a skilled nursing facility for **60 consecutive days**. Per Benefit Period, you pay: **In-Network:** **$0** copayment per day, days 1 to 20 – Skilled Nursing Facility **$203** copayment per day, days 21 to 100 – Skilled Nursing Facility **Out-of-Network:** **$0** copayment per day, days 1 to 20 – Skilled Nursing Facility **$203** copayment per day, days 21 to 100 – Skilled Nursing Facility
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network:** **$0** copayment – PCP's Office – Specialist's Office
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	**In-Network:** **$25** copayment – Specialist's Office – Outpatient Hospital **Out-of-Network:** **$25** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in 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 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.	– Outpatient Hospital
*** Transportation** You are covered for 24 one-way, non-emergency trips to plan-approved locations within the plan service area per calendar year. There is a maximum allowed travel distance of 150 miles per trip. 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. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 5.	**In-Network:** **$0** copayment **Out-of-Network** **50%** coinsurance
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing	**In-Network:** Urgently Needed Services **$50** copayment – Urgent Care Center **Out-of-Network:** Urgently Needed Services **$50** copayment – Urgent Care Center

Services that are covered for you	What you must pay when you get these services
for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. 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 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. See "Physician/Practitioner services, including doctor's office visits" for additional information about urgently needed services provided in a physician's office.	
Vision care Covered services include: • 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 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 • 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) • Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses, or anti-reflective coating) The (preventive service) only applies to Glaucoma Screening.	**In-Network:** Medicare Covered Vision Services **$50** copayment – Specialist's Office Glaucoma Screening **$0** copayment – Specialist's Office Diabetic Eye Exam **$0** copayment – All Places of Treatment Eyewear (Post Cataract Surgery) **$0** copayment – All Places of Treatment **Out-of-Network:** Medicare Covered Vision Services **$50** copayment – Specialist's Office Glaucoma Screening **$0** copayment – Specialist's Office Diabetic Eye Exam **$0** copayment – All Places of Treatment Eyewear (Post Cataract Surgery)

Services that are covered for you	What you must pay when you get these services
	$0 copayment – All Places of Treatment **Supplemental vision benefits** *You are covered for supplemental vision benefits. See the supplemental vision benefit description at the end of this chart for details. **Please note:** the network of providers for your supplemental vision benefits may be different than the network of providers for the Original Medicare vision benefits listed above.
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.	**In-Network:** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. **Out-of-Network:** **$0** copayment – PCP's Office

Mandatory Supplemental Dental Benefit DEN281

Coverage Description
You may receive the following non-Medicare covered routine dental-related services:

Deductible	**$0**	
Annual Maximum	**$2,000**	
Description of Benefit	**In-Network You Pay***	**Out-of-Network You Pay****
Preventive Services		
Exams – Frequency/Limitations – 2 procedure codes per calendar year		
Periodic oral exam	**0%**	**0%**
Exams – Frequency/Limitations – 1 procedure code per calendar year		
Emergency diagnostic exam	**0%**	**0%**
Bitewing X-rays – Frequency/Limitations – 1 set per calendar year		
Bitewing x-rays	**0%**	**0%**

Description of Benefit	In-Network You Pay*	Out-of-Network You Pay**
Intraoral X-rays (inside the mouth)– Frequency/Limitations – 1 set per calendar year		
Periapical x-rays	**0%**	**0%**
Occlusal x-rays	**0%**	**0%**
Full Mouth or Panoramic X-rays – Frequency/Limitations – 1 procedure code every 5 calendar years		
Complete series	**0%**	**0%**
Panoramic film	**0%**	**0%**
Prophylaxis (Cleaning) – Frequency/Limitations – 2 procedure codes per calendar year		
Prophylaxis (cleaning)	**0%**	**0%**
Periodontal Maintenance – Frequency/Limitations – 4 procedure codes per calendar year		
Periodontal maintenance following periodontal therapy	**0%**	**0%**
Fluoride – Frequency/Limitations – 2 procedure codes per calendar year		
Topical fluoride application	**0%**	**0%**
Comprehensive Services		
Restorations (Fillings) – Amalgam and/or Composite – Frequency/Limitations – Unlimited procedure codes per calendar year		
Amalgam (silver) – primary or permanent	**0%**	**0%**
Resin-based composite (white) – anterior (front) or posterior (back)	**0%**	**0%**
Extractions (Pulling Teeth) – Frequency/Limitations – Unlimited procedure codes per calendar year		
Extraction, erupted tooth, or exposed root	**0%**	**0%**
Surgical removal of erupted tooth	**0%**	**0%**
Restorative (Other Services) – Core Buildup or Prefabricated Post and Core – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Core buildup	**0%**	**0%**
Prefabricated post and core	**0%**	**0%**
Scaling – Generalized Inflammation – Frequency/Limitations – 1 procedure code every 3 calendar years		
Scaling – moderate or severe gingival inflammation	**0%**	**0%**
Scaling and Root Planing – Frequency/Limitations – 1 procedure code every 3 calendar years, per quadrant		
Periodontal scaling and root planing	**0%**	**0%**
Root Canal – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Root canal	**0%**	**0%**
Root Canal Retreatment – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Retreatment of previous root canal therapy	**0%**	**0%**
Crowns – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Crowns (not retainer crowns)	**0%**	**0%**
Onlay	**0%**	**0%**
Inlay – alternate benefit only	**0%**	**0%**

Description of Benefit	In-Network You Pay*	Out-of-Network You Pay**
Complete Dentures – Frequency/Limitations – 1 upper complete and/or 1 lower complete denture every 5 calendar years, including routine post-delivery care		
Complete denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Immediate denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Removable Partial Dentures (including routine post-delivery care) – Frequency/Limitations – 1 upper and/or 1 lower partial denture every 5 calendar years		
Partial dentures – resin or metal, maxillary (upper) or mandibular (lower)	**0%**	**0%**
Unilateral partial denture	**0%**	**0%**
Partial denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Removable unilateral partial denture	**0%**	**0%**
Oral Surgery – Frequency/Limitations – 2 procedure codes per calendar year		
Oral surgery	**0%**	**0%**
Denture Adjustments (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		
Complete denture adjustment– maxillary (upper) or mandibular (lower)	**0%**	**0%**
Partial denture adjustment – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Denture Reline (not allowed on spare dentures or if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		
Reline complete denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Denture Repairs – Frequency/Limitations – 1 procedure code per calendar year		
Repair complete denture base – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Repair partial denture base – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Repair partial denture framework – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Replace missing or broken tooth	**0%**	**0%**
Add tooth or clasp to partial denture	**0%**	**0%**
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Denture Rebase (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		
Rebase complete denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Rebase partial denture – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Tissue Conditioning (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		
Tissue conditioning – maxillary (upper) or mandibular (lower)	**0%**	**0%**
Occlusal Adjustments (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code every 3 calendar years		
Occlusal adjustment – limited	**0%**	**0%**
Occlusal adjustment – complete	**0%**	**0%**

Description of Benefit	In-Network You Pay*	Out-of-Network You Pay**
Pain Management – Frequency/Limitations – 2 procedure codes per calendar year		
Palliative (emergency) treatment of dental pain	**0%**	**0%**
Anesthesia – Frequency/Limitations – As needed with covered procedures		
Analgesia, anxiolysis, inhalation of nitrous oxide	**0%**	**0%**
Deep sedation/general anesthesia	**0%**	**0%**
Intravenous moderate (conscious) sedation/analgesia	**0%**	**0%**
Application of desensitizing medicament	**0%**	**0%**
Recementation of Crown – Frequency/Limitations – 1 procedure code every 5 calendar years		
Recement inlay, onlay or partial coverage restoration	**0%**	**0%**
Recement indirectly fabricated or prefabricated post and core	**0%**	**0%**
Recement crown	**0%**	**0%**
Diagnostic Services – Frequency/Limitations – 1 procedure code every 3 calendar years		
Periodontal exam	**0%**	**0%**
Comprehensive oral evaluation	**0%**	**0%**

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

*In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

**Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information or visit Humana.com for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare**.

How Payments to You or Your Dentist Are Calculated

For covered dental services, we will pay as follows:

- We will determine the total covered expense.
- We will review the covered expense against the maximum benefits allowed.
- We will check to see if you have met your deductible, if applicable. If you have not, you will be required to pay the covered expense up to the amount of the deductible.
- We will pay the remaining expense to you or your dentist, minus any coinsurance you owe (the procedure you received may require you to pay a percentage of the cost).

For dental conditions that have two or more possible treatments, Humana will cover the lowest cost treatment, as long as it is proven to provide satisfactory results. If you choose to receive a higher cost treatment, you will be responsible to pay for the difference.

Submitting Pretreatment Plans

If the dental care you need is expected to exceed **$300**, we suggest you or your dentist send a dental treatment plan for us to review ahead of time so that we can provide you with an estimate for services. The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association nomenclature and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.
5. Any other diagnostic materials we request.

Mandatory Supplemental Hearing Benefit HER947

Coverage Description

To use your benefit, you must call TruHearing at 1-844-255-7144 to schedule an appointment.

Description of Benefit	You Pay
Routine hearing exam (1 per year)	**In-Network You Pay:** **$0***
Up to 2 TruHearing-branded hearing aids every year (1 per ear per year). Benefit is limited to the TruHearing Advanced and Premium hearing aids, which come in various styles and colors. Advanced and Premium hearing aids are available in rechargeable style options for an additional $50 per aid. **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).** In-network hearing aid purchase includes: – Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase – 60-day trial period – 3-year extended warranty – 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: – OTC hearing aids – Additional cost for optional hearing aid rechargeability – Ear molds – Hearing aid accessories – Additional provider visits – Additional batteries (or batteries when a rechargeable hearing aid is purchased) – Hearing aids that are not TruHearing-branded hearing aids – Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and are not covered by the plan.	**In-Network You Pay:** **$99** per Advanced Aid or **$399** per Premium Aid ***Out-of-Network You Pay:** **50%** coinsurance If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 5.

Copayment, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.

These benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

Mandatory Supplemental Vision Benefit VIS694

Coverage Description

Vision benefit through Humana Medicare Insight Network
You may receive the following non-Medicare covered routine vision-related services:

Description of Benefit	In-Network You Pay	Out-of-Network You Pay
• Routine Eye Exam (includes refraction) (1 per calendar year) by a **Humana Medicare Insight Network** optical provider – **$75** allowance* OR • Refraction exam (1 per calendar year) when completed at the same appointment as a Medicare covered comprehensive eye exam by a Humana network medical optical provider.	**$0** **$0** for refraction exam in addition to the Medical Specialist cost-share for the medical exam	Any amount over **$75*** Any amount over **$15** for refraction exam in addition to your Medical Specialist cost-share for the medical exam, and any costs that are above the plan approved amount
• Eyewear Benefit (1 per calendar year) at a Humana Medicare Insight Network optical provider You have a choice of: – **$50** allowance toward the purchase of frame and pair of lenses **OR** toward the purchase of contact lenses (conventional or disposable) **OR** – **$100** allowance toward the purchase of frame and pair of lenses **OR** toward the purchase of contact lenses (conventional or disposable) **from a PLUS** provider** Benefit does not include contact lens fitting. Ultraviolet protection, scratch resistant coating, and other lens options may be applied toward the eyeglass allowance benefit. Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan-approved amount. **The benefit can only be used one time. Any remaining benefit dollars do not "roll over" to a future purchase.** Members are reimbursed up to a plan maximum benefit amount at an out-of-network provider.	Any retail amount over **$50** OR Any retail amount over **$100** from a **PLUS** provider**	Any retail amount over **$50**

*Your routine exam charge will not exceed **$75** at a **Humana Medicare Insight Network** optical provider. Please inform the network provider that you are part of the Humana Medicare Insight Network. **NOTE**: The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. When using an out-of-network provider, you will be responsible for costs above the plan approved amount. You are responsible for submitting a Humana Vision Care

out-of-network claim form with itemized receipt when seeing a non-Humana Medicare Insight provider. Claim forms can be found by logging into your profile on MyHumana.

PLUS providers are part of the **Humana Medicare Insight Network and will display the PLUS Provider indicator in the provider locator search results.

The provider locator for the Humana Medicare Insight Network for routine vision can be found at **Humana.com > Find a Doctor > select the Vision Care icon > select Medicare > select Medicare Advantage plans**.

The provider locator for Medicare-covered vision can be found at **Humana.com > Find a Doctor > select the Medical icon > enter Zip Code > select look up Method > Medicare or Medicare-Medicaid > select your plan Network > select Search Category > Specialty Physician**.

Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.

Note: Benefits are offered on a calendar year basis. If these benefits are changed or eliminated next year or the year after and you have not used these benefits, you are no longer eligible for the benefits described above.

Section 2.2 Extra "Optional Supplemental Benefits" you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and are not included in your benefits package as a plan member. These extra benefits are called **"Optional Supplemental Benefits."** If you want these optional supplemental benefits, you must sign up for them and you will have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

A Dental OSB offers different coverage than the dental benefits described in your supplemental dental benefit package. If you need more dental coverage, you should consider a Dental OSB. You can review the Dental OSB options available to you below. The charts outline the benefits you will get instead of the benefits offered as part of your supplemental dental benefit package. For example, the OSB benefits may reduce costshare or cover additional benefits. The Maximum plan benefit (e.g., the maximum amount the plan will pay for dental care during the plan year) and/or frequency of covered services may change. Please note, the Maximum plan benefit available to you is **$2,000**.

If you purchase any of these Optional Supplemental Benefits (OSBs), this *Evidence of Coverage* contract also will apply to them. The OSB payment method must be the same as the Medicare Advantage payment method. For more information about your payment options, please call Customer Care at the phone number that appears at the end of this section or on the back of your Humana member ID card.

Optional Supplemental Benefits (OSBs)

Enrollment in Optional Supplemental Benefits

Optional Supplemental Benefits are dental, vision or fitness benefits that are not part of your Medicare Advantage plan. You must purchase them separately. The Optional Supplement Benefits available to you vary by plan.

You can enroll into OSBs in two ways:

1. Enroll at the same time you enroll in your Medicare Advantage plan. In most cases, your OSBs will begin on the same day your Medicare Advantage plan begins.
2. Enroll anytime by filling out an application. You can also call **1-800-645-7322** (TTY: **711**), Monday – Friday, 8 a.m. – 8 p.m. local time. Your coverage will begin the first day of the month after Humana receives your application.

OSBs are offered on an annual basis. If you don't change your Medicare Advantage plan during the next annual election period and your OSB is still available, you will be automatically reenrolled in your OSB. If your OSB is discontinued or is being changed in any way for the following plan year, we will notify you before the annual election period in the Annual Notification of Changes mailing. Unused benefits will not "roll over" to the next coverage year.

For more information, call Customer Care at the phone number that appears at the end of this section or on the back of your Humana member ID card.

Finding a Provider

We will send you an OSB provider directory within 10 days of enrolling in an Optional Supplemental Benefit. However, if you want the name of a provider, you may call Customer Care.

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.

Optional Supplemental Benefits Disenrollment

If you want to cancel your OSB coverage, call Customer Care (phone number on the back of the ID card), send the request by fax to 800-633-8188 or by mail to:

Humana
PO Box 14168
Lexington, KY 40512-4168

Your letter should:
- Tell us clearly that you want to disenroll from the OSB(s) only – not the Medicare Advantage plan.
- Include your name, member ID number and signature.

The termination date will be the last day of the month from when the request is received.

If you do not pay the premiums for your OSBs, you will lose your OSB coverage. We will tell you in writing that you have 60 days to pay the OSB premium. If you have not paid everything you owe at the end of that grace period, your OSB coverage will end.

If you cancel these benefits or if you lose them because you did not pay what you owe, you can sign up again anytime in the year. Any claims that were previously processed in the original coverage will count toward your benefit maximum. Your benefits will not start over.

Premium Refund

If you cancel your OSB and have overpaid your premium, we will issue a refund within 45 business days.

Optional Supplemental Benefits Available to You

OSB Plan name	Additional monthly cost to you
MyOption DEN478	**$ 46.40**

Plan options are described in detail below.

MyOption DEN478

MyOption DEN478 is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new DEN478 listed on the back. Any claim paid under the current year MSB will apply toward the annual OSB maximum plan benefit.

Monthly Cost	
Monthly premium	**$46.40**
Coverage Information	
Maximum plan benefit (combined in and out-of-network)	**$2,000** per calendar year
Deductible	**$0** per calendar year

You may receive the following dental services:

Plan covers up to **$2,000** allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire.

Your benefit can be used for most dental treatments such as:

- Preventive dental services, such as exams, routine cleanings, etc.
- Basic dental services, such as fillings, extractions, etc.
- Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.

Note: The allowance cannot be used on cosmetic services and implants.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

Out-of-network dentists have not agreed to provide covered services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) or usual and customary fees in your area. See Chapter 2 Payment Requests Contact Information or visit Humana.com for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare**.

How Payments to You or Your Dentist Are Calculated

For covered dental services, we will pay as follows:

- We will determine the total covered expense.
- We will review the covered expense against the maximum benefits allowed.
- We will check to see if you have met your deductible, if applicable. If you have not, you will be required to pay the covered expense up to the amount of the deductible.
- We will pay the remaining expense to you or your dentist, minus any coinsurance you owe (the procedure you received may require you to pay a percentage of the cost).

For dental conditions that have two or more possible treatments, Humana will cover the lowest cost treatment, as long as it is proven to provide satisfactory results. If you choose to receive a higher cost treatment, you will be responsible to pay for the difference.

Submitting Pretreatment Plans

If the dental care you need is expected to exceed **$300**, we suggest you or your dentist send a dental treatment plan for us to review ahead of time so that we can provide you with an estimate for services. The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association nomenclature and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.
5. Any other diagnostic materials we request.

An estimate for services is not a guarantee of what we will pay. It tells you and your dentist in advance about the benefits payable for the covered expenses in the treatment plan.

An estimate for services is valid for 90 days after the date we notify you and your dentist of the benefits payable for the proposed treatment plan. This is subject to your eligibility of coverage at time of treatment. If treatment does not begin for more than 90 days after that date, we recommend you submit a new treatment plan.

Other Provisions

It's your responsibility to understand your dental coverage, including its limitations and exclusions.

All dental services must be received from a licensed dentist.

We may access your dental and treatment records to determine benefits, to process claims, to perform financial audits and other purposes.

If you or your dentist do not send us the documents we need, we can decide not to pay for your treatments.

The benefits of this optional supplemental benefit are subject to the same appeals process as any other plan benefit.

Limitations and Exclusions

These limitations and exclusions apply to:

- MyOption DEN478

Does not include coverage for the following:

1. Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services that are:
   a. Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
   b. Furnished by, or payable under, any plan or law through any government or any political subdivision - this does not include Medicare or Medicaid.
   c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.

Limitations and Exclusions

6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures:
   a. Facings on crowns or pontics - the portion of a fixed bridge between the abutments - posterior to the second bicuspid.
   b. Any service to correct congenital malformation.
   c. Any service performed primarily to improve appearance; or characterization and personalization of prosthetic devices.
7. Charges for any type of implant and all related services, including crowns or the prosthetic device attached to it; precision or semi-precision attachments; over-dentures and any endodontic treatment associated with over-dentures; other customized attachments.
8. Any service related to:
   a. Altering vertical dimension of teeth.
   b. Restoration or maintenance of occlusion.
   c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
   e. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in the Coverage Information.
14. Any service that we determine is not a dental necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
15. Orthodontic services.
16. Any expense incurred before your effective date or after the date this optional supplemental benefit terminates.
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. MyOption DEN478: Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Extractions, except for extractions of erupted tooth or exposed root (includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary), or surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone of section of tooth.

Excess Coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other insurance is described as primary, excess or contingent.

If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this dental plan. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductibles.

Questions?

For more information about
MyOption DEN478
call HumanaDental Customer Care at
1-800-669-6614
For TTY, call **711**
Monday - Friday, 8 a.m. - 6 p.m. local time

Visit **Humana.com**

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.

The chart below lists some 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 except under the specific conditions listed 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. The only exception is if the service is appealed and decided 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 document.)

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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Charges for equipment which is primarily and customarily used for a nonmedical purpose, even though the item has some remote medically related use.		• Covered only when medically necessary.
Cosmetic surgery or procedures		• 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.
Custodial care 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.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• 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.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care.		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for a people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		• Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards.	**Not covered under any condition**	
Purchase, instead of rental, of durable medical equipment that Original Medicare does not allow to be purchased outright.	**Not covered under any condition**	

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Radial keratotomy, LASIK surgery, and other low vision aids and services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, 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.

Dental Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).
- You have the option to replace a comparable amalgam filling with a composite filling on posterior (back) teeth.

- Initial placement or replacement of a prior denture that is unserviceable and cannot be made serviceable. Spare dentures are not covered.
- Dental reline may not be covered within six months of initial denture placement or on spare dentures.
- Dental adjustments may not be covered within six months of initial denture placement or on spare dentures.
- Expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Any expense arising from the completion of forms.
- Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures to include, but are not limited to:
  - Facings on crowns or pontics – the portion of a fixed bridge between the abutments – posterior to the second bicuspid.
  - Any service to correct congenital malformation.
  - Any service performed primarily to improve appearance;
  - Characterizations and personalization of prosthetic devices; or
  - Any procedure to change the spacing and/or shape of the teeth
- Charges for:
  - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
  - Precision or semi-precision attachments;
  - Other customized attachments
  - Temporary or interim dental services;
  - Additional charges related to material or equipment used in the delivery of dental care;
  - The removal of any implants unless a covered service.
- Any service related to:
  - Altering vertical dimension of teeth.
  - Restoration or maintenance of occlusion.
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
  - Bite registration or bite analysis.
- Infection control, including but not limited to sterilization techniques.
- Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in the Coverage Information.
- Any service that is not eligible for benefits based upon clinical review; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Orthodontic services.

- Retainer Crown services when bridge coverage is not included in the benefit.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the reimbursement limit for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models/diagnostic casts, treatment plans, occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy. A separate fee for these services is not considered a covered expense.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
  - Any services for orthognathic surgery;
  - Any services for destruction of lesions by any method;
  - Any services for tooth transplantation;
  - Any services for removal of a foreign body from the oral tissue or bone;
  - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
  - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
  - Pain control unless a documented allergy to local anesthetic is provided.
  - Anxiety.
  - Fear of pain.
  - Pain management.
  - Emotional inability to undergo surgery.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the Coverage Information.
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.

Hearing Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Any fees for exams, tests, evaluations or any services in excess of the stated maximums.

- Any expenses which are covered by Medicare or any other government program or insurance plan, or for which you are not legally required to pay.
- Services provided for clearance/consultation by a provider.
- Any refitting fees for lost or damaged hearing aids.
- Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the covered limit).
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.
- These benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

Vision Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Refitting or change in lens design after initial fitting.
- Any expense arising from the completion of forms.
- Any service not specifically listed in your supplemental benefit.
- Orthoptic or vision training.
- Subnormal vision aids and associated testing.
- Aniseikonic lenses.
- Athletic or industrial lenses.
- Prisms (not covered with allowance, but may be available at a discounted rate off retail price; check with provider for details)
- Any service we consider cosmetic.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the allowance for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Plano lenses.
- Medical or surgical treatment of eye, eyes or supporting structures.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plans providing vision care.
- Corrective vision treatment of an experimental nature.
- Solutions and/or cleaning products for glasses or contact lenses.
- Non-prescription items.
- Costs associated with securing materials.
- Pre and post-operative services.
- Orthokeratology.
- Routine maintenance of materials.
- Artistically painted lenses.
- Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.

- Your failure to keep an appointment.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Replacement of lenses or eyeglass frames furnished under this supplemental benefit that are lost or broken, unless otherwise available under the supplemental benefit.
- Any examination or material required by an employer as a condition of employment or safety eyewear.
- Pathological treatment.
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.
- These benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

- The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, 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 be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First, try to resolve the bill with the provider. If that does not work, send the 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. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

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 care from a provider who is not in our plan's network

You can receive emergency services or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, 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.
- 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.

- 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. (This 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 such as receipts and bills for us to handle the reimbursement.

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 document 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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send 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. **You must submit your Part C (medical and dental) claim to us within 12 months** of the date you received the service, item, or Part B drug.

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. The data we need to make a decision are: your name and the member ID from your Humana ID card, an itemized statement from the provider showing the services provided with the date(s) of service for those services, and your receipt or other proof of your payment. We also need the revenue code(s), if applicable; relevant CPT and HCPCS code(s); diagnosis code(s); and the place of treatment. Those may be included on the provider's itemized statement, but you will need to provide them if they are not.
- Either download a copy of the form from our website (**https://www.humana.com/member/documents-and-forms**) or call Customer Care and ask for the form.

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

Requests for payment for Medical and Dental Services:
Humana
P.O. Box 14601
Lexington, KY 40512-4601

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, 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.
- 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. We will send you a letter explaining the reasons why we are not sending the payment and your right 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 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. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

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

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

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from 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.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

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, TTY 711. 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 1-800-368-1019 or TTY 1-800-537-7697.

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera competente desde el punto de vista cultural y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con orígenes culturales y étnicos diversos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, telemáquinas de escribir o conexión TTY (teléfono de texto o teléfono de telemáquina).

Nuestro plan cuenta con servicios gratuitos de intérpretes disponibles para responder preguntas de afiliados 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.

Nuestro plan debe brindarles a las mujeres inscritas la opción de acceso directo a un especialista en salud femenina dentro de la red para servicios de cuidado de la salud preventivos y de rutina para mujeres.

Si no hay disponibles proveedores de la red del plan para una especialidad, es responsabilidad del plan localizar proveedores especializados fuera de la red que le proporcionen el cuidado necesario. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la cual no hay especialistas en la red del plan que cubran un servicio que usted necesita, llame al plan para obtener información sobre dónde ir para obtener este servicio al costo compartido dentro de la red.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja formal ante el Departamento de quejas formales y apelaciones de Humana al 1-800-457-4708, TTY 711. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You may seek care from any provider in the United States if the provider agrees to accept our plan's terms and conditions of payment prior to providing services to you and is eligible to provide services under Original Medicare, as described in Chapter 3, Section 1.2. You should always (except possibly in emergencies) show the provider your PFFS plan membership card. As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time.*

Our plan has agreements with some providers to deliver covered services to members in our plan. These providers are our network providers. Chapter 3, Section 1.2 describes the rules for getting covered services using our network providers.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 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.
- You have rights related to your 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- We are required to release health information to government agencies that are checking on 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; typically, this requires that information that uniquely identifies you not be shared.

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 by 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 health care 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.

Insurance ACE
Notice of Privacy Practices

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 do not need to do anything unless you have a request or complaint.
This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at https://huma.na/insuranceace

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 nonpublic personal or health information?
Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term “information” in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?
We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?
The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical 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 healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, 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 must 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 opted out, 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 and provided that they have taken appropriate measures to protect your privacy.
- 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. As required under applicable law, we will make this personal information available to you or to your designated representative.
- 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.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- 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 time.
- 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.

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

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.

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.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

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 **Humana.com** and going to the Privacy Practices link
- Send completed request form to:

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

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

As a member of Humana Gold Choice H8145-042 (PFFS), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.

- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding 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 Advice Line team at 1-800-491-4164, TTY 711.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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. 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.** 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.

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 of 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.** You can get an advance directive 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. You can also contact Customer Care to ask for the forms.

- **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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. 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**.

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

Remember, it is your choice 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 document.

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. Members may 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, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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, sexual orientation, 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**.
- You can **call the SHIP**. For details, 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 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**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *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 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* 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.

- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **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 get the best care, tell your doctors and other health providers about your health problems. 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 and get an answer you can understand.
- **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:
  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
  - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

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

SECTION 1 Introduction

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

This chapter explains two processes for handling problems and concerns:

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

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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 make things easier, this chapter:

- Uses 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Customer Care for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. 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 document.

Medicare

You can also contact Medicare to get help. To contact 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 also visit the Medicare website (www.medicare.gov).

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

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.

Is your problem or concern about your benefits or coverage? This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.	
Yes. Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**	**No.** 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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. 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 care before you receive it, you can ask us to make a coverage decision for you. 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.

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 medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a service is received, 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. Under certain circumstances, which we discuss later, you can request an expedited or fast appeal of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal 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 Level 1 appeal, 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 for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals.

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 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Care**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **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.
  - If you want a friend, relative, or another person to be your representative, call Customer Care 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.
  - 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.
- **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. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. 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. **Ask for a coverage decision. Section 5.2.**
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. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
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. **Make an appeal. Section 5.3**.

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 Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only* ask for coverage for medical care items and/or services (not requests for payment for items and/or services 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 do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines

- Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines

This 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,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we 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. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we 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. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
  - **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 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again 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.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 days or 7 days for Part B drugs. A fast appeal is generally made within 72 hours.

- 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. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a Fast appeal.

- **If you are asking for a standard appeal, submit your standard appeal in writing.**
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, 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. Section 5.4 explains the Level 2 appeal 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 send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet 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.)

  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period), we will send your request on to a Level 2, where an independent review organization will review the appeal. 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, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, 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.

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

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and it is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- 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

- For the fast appeal 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

- For the standard appeal 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. For expedited requests, we have 72 hours from the date we receive the decision from the review.

- **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**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **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.) In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. 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.
  - Telling you how to file a Level 3 appeal.

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 you want to go to a Level 3 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 explains the Level 3, 4, and 5 appeals processes.

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

Chapter 5 describes when 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.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care 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. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** 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 medical care and the reasons why.

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. For appeals concerning reimbursement, please note:

- 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, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged 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.

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 tell you.
- 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.

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

Within two days of being admitted to the hospital, 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. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Care or 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:
   - 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.
   - Where to report any concerns you have about quality of your hospital care.

- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This 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.

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 must sign the notice.

   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

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

- **Meet the deadlines.**

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

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. 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.

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**.
  - **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.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge.** This notice 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.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care 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 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) 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 told us of your appeal, you will get a written notice that gives your planned discharge date. This notice also 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.

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*, **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.

What happens if the answer is no?

- If the review organization says *no*, 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 said *no* to 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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

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 stayed 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 Level 2 appeal, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **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. 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.

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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 to change your hospital discharge date?

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

You can appeal to us instead

As explained above in Section above, you must act quickly to start your first appeal of your hospital discharge date. 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

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

- **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. Chapter 2 has contact information.

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.

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. We will keep providing your covered inpatient hospital services for as long as they are 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.

Step-by-Step: Level 2 Alternate Appeal Process

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

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. 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.

- 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 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 written notice you get from the independent review organization will tell you how to start a Level 3 appeal with the review process, 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 appeal.

- 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

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

Legal Term
The written notice tells 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.

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care. This notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a *fast track appeal* to request us to keep covering your care for a longer period of time.
2. **You or someone who is acting on your behalf, will be asked to sign the notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> 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.**
- **Meet the deadlines.**

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received *(Notice of Medicare Non-Coverage)* 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.

Act quickly:

- 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.

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) 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 review organization will also look at your medical information, talk with your doctor, and review the information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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?

- 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).There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- 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.

- 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 a Level 2 appeal.

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

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.

Step 1: 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?

- **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.

- 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.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, 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

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

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

- **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. Chapter 2 has contact information.

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.

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 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 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.

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

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. **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.

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. 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.

- 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 pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must 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 go on to a Level 3 appeal.

Step 3: If the independent review organization says no to 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, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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.

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**. Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care 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 medical care 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. The notice you get will tell you what to do for a Level 4 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** - Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care 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.**
  - 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 may 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 and how to continue with a Level 5 appeal.

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

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

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?

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

Complaint	Example
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 share confidential information about you that you?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • 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 exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
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 decision or making an appeal, you use that process, not the complaint process. 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: • You asked us to give you a *fast coverage decision* or a *fast appeal*, and we have said no, you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals, you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services, that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

- A **complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 9.3 Step-by-step: Making a complaint

<u>Step 1:</u> 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.
- **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.
- Call 1-800-457-4708, TTY 711 from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30.
- **Grievance Filing Instructions**
  File a verbal grievance by calling Customer Care at 1-800-457-4708, TTY 711

  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 are printed on the back cover 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.

- **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.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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.

- **Most complaints are answered in 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 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**.
- **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 include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

You can make your complaint to the Quality Improvement Organization.

- 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Humana Gold Choice H8145-042 (PFFS) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also 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

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Humana Gold Choice H8145-042 (PFFS) 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where 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,our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the *Annual Open Enrollment Period*). During this time, review your health coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan with or without prescription drug coverage;
  - Original Medicare *with* a separate Medicare prescription drug plan;
  - Original Medicare *without* a separate Medicare prescription drug plan.
- **What do you need to do to switch plans?**
  - If you want to switch to Original Medicare: You must ask to disenroll from our plan. For more information on how to request disenrollment contact Customer Care. You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to request disenrollment from our plan. TTY users should call 1-877-486-2048.
  - If you are currently enrolled in a separate Medicare prescription drug plan:
    > Leaving our plan will not affect your enrollment in your drug plan.
    > If you want to join a new drug plan, you must request enrollment in the new drug plan of your choice. Switching your Medicare prescription drug plan will *not* automatically disenroll you from our plan.
  - If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare health plan that does not offer drug coverage or you can switch to Original Medicare.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you are enrolled in a separate Medicare prescription drug plan, you may not cancel that coverage when you switch to Original Medicare.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Humana Gold Choice H8145-042 (PFFS) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. 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.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **The enrollment time periods vary depending on your situation.**
- **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. You can choose:
  - Another Medicare health plan with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

OR

– Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Care.**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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:
• Another Medicare health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. You will automatically be disenrolled from Humana Gold Choice H8145-042 (PFFS) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. **Then contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled.** • 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 Gold Choice H8145-042 (PFFS) when your coverage in Original Medicare begins. If you join a Medicare prescription drug plan, that coverage should begin at this time as well.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Contact Customer Care and ask to be disenrolled from the plan**. • 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 Gold Choice H8145-042 (PFFS) when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical items, services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical services, items through our plan.

- **Continue to use our network providers to receive medical care.**
- **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 Gold Choice H8145-042 (PFFS) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Humana Gold Choice H8145-042 (PFFS) 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, call Customer Care to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer 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.)
- 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 call Customer Care for more information.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Humana Gold Choice H8145-042 (PFFS) 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, 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 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.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Care. 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, Humana Gold Choice H8145-042 (PFFS), 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:

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.

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.

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 healthcare 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 healthcare 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 section 4 of this chapter, **Additional Notice about Subrogation (Recovery from a Third Party)** for more information on our recovery rights.

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 - Specialized imaging method that takes more detailed images than standard x-rays. There are several kinds of imaging services, including Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan or other similar technology.

Allowed Amount - The maximum amount a plan will pay for a health care benefit.

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.

Annual Enrollment Period - The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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.

Balance Billing - When a provider (such as a doctor or hospital) bills a patient up to 15% more than the plan's payment amount for services. The "balance billing" amount is collected in addition to the patient's regular plan cost-sharing amount. See Chapter 4, Section 1.6 for more information about balance billing.

Benefit Period - The way that Original Medicare measures your use of skilled nursing facility (SNF) services. For our plan, you will have a benefit period for your skilled nursing facility benefits. A SNF benefit period begins the day you go into a skilled nursing facility. The benefit period will accumulate one day for each day you are at a SNF. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance - An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services after you pay any deductibles.

Complaint - The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive oral exam/evaluation- This code applies when a general dentist and/or dental specialist examines the patient. It applies to: new patients, established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have not had active treatment for three or more years.

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that mainly provides rehabilitation services after an illness or injury, 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 health plan pays to an in-network doctor or provider 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 drug. A copayment is a set amount (for example $10), rather than a percentage.

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 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.

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, provided by people who do not have professional skills or training, includes 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.

Deductible - The amount you must pay for health care before our plan pays.

Deemed Provider - A doctor that has agreed to treat members of a health plan for a standard amount the plan pays.

Diagnostic Mammogram - A specialized x-ray exam given to a patient who shows signs or symptoms of breast disease.

Diagnostic Procedure - An exam to identify a patient's strengths and weaknesses in a specific area, in order to find out more about their condition, disease, or illness.

Disenroll or Disenrollment - The process of ending your membership in our plan.

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 (and if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. 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) provided 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 or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Freestanding Dialysis Center - A licensed health facility, other than a hospital, that provides dialysis treatment with no overnight stay.

Freestanding Lab - A licensed health facility, other than a hospital, that provides lab tests to prevent, identify, or treat an injury or illness, with no overnight stay.

Freestanding Radiology (Imaging) Center - A licensed health facility, other than a hospital, that provides one or more of the following services to prevent, identify, or treat an injury or illness, with no overnight stay: X-rays; nuclear medicine; radiation oncology (including MRIs, CT scans and PET scans).

Grievance - A type of complaint you make about our plan, providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Health Maintenance Organization (HMO) - A type of health insurance plan where members must receive care from the plan's network of doctors, hospitals, and other health care providers.

Home Health Aide - A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care - Skilled nursing care and certain other health care services given to a patient in their own home for the treatment of an illness or injury. Covered services are listed in Chapter 4 under the heading, "Home health agency 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 fulltime nursing care at home.

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. 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.

Hospice Care - Specialized care for people who are terminally ill, focused on comfort not cure. This also includes counseling for patients' families. Depending on the situation, this type of care may be in the home, a hospice facility, a hospital, or a nursing home, and is given by a team of licensed health professionals.

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. 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.

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.

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 Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.3 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. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary - Services or supplies 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).

Medicare Advantage Open Enrollment Period - The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage Organization - A private company that runs Medicare Advantage Plans to offer members more options, and sometimes extra benefits. Medicare Advantage Plans are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage, and some may also provide Part D (prescription drug) coverage.

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 and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

Medicare Allowable Charge - The most amount of money that can be charged for a particular medical service covered by Medicare. These are set amounts decided by Medicare.

Medicare-Covered Services - Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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 - see "Network Provider"

Network Provider -**Provider** is the general term 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. **Network providers** 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. Network providers are also called *plan providers*.

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 - Outpatient hospital 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.

Optional Supplemental Benefits - Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination - A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (**Traditional Medicare** or **Fee-for-service** Medicare) - Original Medicare is offered by the government, and not a private health plan like 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, Humana Gold Choice H8145-042 (PFFS).

Out-of-Network Provider or Out-of-Network Facility - A provider or facility that does not have a contract with our plan 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.

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.

PACE plan - A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C - see Medicare Advantage (MA) Plan.

Part D - The voluntary Medicare Prescription Drug Benefit Program.

Periodic oral exam - An exam done on established patients to determine changes in dental and health status since a previous periodic or comprehensive evaluation.

Periodontal scaling and root planing - Scaling is a common dental procedure for patients with gum disease. This is a type of dental cleaning that reaches below the gumline to remove plaque buildup. The process of scaling and root planing the teeth is often referred to as a deep cleaning.

Plan Provider – see "Network Provider".

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 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 Provider (PCP) - The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization - Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. In a PFFS plan, you do not need prior authorization to obtain services. However, you may want to check with your plan before obtaining services to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Private-Fee-for-Service (PFFS) Plan - A health plan that lets its members use any Medicare-approved providers, hospitals, and facilities who agree to accept the plan's standard payment on a fee-for-service basis.

Prophylaxis (cleaning) - Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. Prophylaxis is only for people who do not exhibit any of the signs and symptoms of periodontal disease, including bone loss, bleeding, mobility, exudate, and recession. Prophylaxis is, thus, a preventive procedure for patients who don't yet have periodontal disease and should only be used with patients who are periodontally healthy.

Prosthetics and Orthotics – Medical devices including, 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.

Radiology - X-rays and other specialized procedures that use high-energy radiation to identify and treat diseases.

Rehabilitation Services - These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram - A specialized x-ray procedure to find out early if a patient has breast cancer.

Service Area - A geographic area where you must live to join a particular health plan. 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 care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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 licensed health facility where doctors and nurses provide services to identify and treat a sudden injury or illness, with no overnight stay.

Urgently Needed Services - Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Exhibit A- State Agency Contact Information

This section provides the contact information for the state agencies referenced in Chapter 2 and in other locations within this Evidence of Coverage. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

VIRGINIA	
SHIP Name and Contact Information	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) http://www.vda.virginia.gov
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Department of Medical Assistance Services 600 East Broad Street Suite 1300 Richmond, VA 23219 1-855-242-8282 (toll free) 1-804-786-7933 (local) 1-888-221-1590 (TTY) http://www.dmas.virginia.gov/

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, ethnicity, marital status, religion, or language. 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 **1-877-320-1235** 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 the 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.
1-877-320-1235 (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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线 : 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線 : 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Notes

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Humana Gold Choice H8145-042 (PFFS) Customer Care

Method	Customer Care – Contact Information
CALL	1-800-457-4708 Calls to this number are free. You can call us seven days a week, from 8 a.m. to 8 p.m. 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. Hours of operation are the same as above.
FAX	1-877-837-7741
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com/customer-support**

State Health Insurance Assistance Program
The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Contact information for your SHIP can be found in "Exhibit A" in this document.

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