Your 2025 Evidence of Coverage

Humana®

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Thanks for being a Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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.

2025

Evidence of Coverage

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)

This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

Puerto Rico
Puerto Rico Island Wide

Humana®

January 1 - December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)

This document gives you the details about your Medicare and Medicaid health care and prescription drug coverage from January 1 - December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-866-773-5959. (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, and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 30. This call is free.

This plan, Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP), is offered by Humana Health Plans of Puerto Rico, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Humana Health Plans of Puerto Rico, Inc. When it says "plan" or "our plan," it means Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP).)

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2025 based on a review of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)'s Model of Care.

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, 2026.

The formulary, 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 and prescription drug 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.

To notify Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) about any instance of suspicion or fraud against the health plan, please contact Humana's Fraud Hotline at 1-800-614-4126 (TTY 711), between 8 a.m. and 4 p.m. Eastern standard time, after normal business hours you may leave a message.

You can also visit oig.hhs.gov or call the fraud hotline of the Department of Health and Human Services Office of the Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950.

Whistleblowers

A whistleblower is someone who reports suspected or detected misconduct that would be considered an action against company policy or federal or state rules, laws or regulations. In the context of the False Claims Act, whistleblower protections apply to actions taken to prevent False Claims Act violations. These whistleblower protections prevent retaliation against the whistleblower. If any retaliation does occur, the whistleblower has a right to obtain legal counsel to defend the actions he or she has taken.

OMB Approval 0938-1051 (Expires: August 31, 2026)

All references to age 0-20 represents 0-20 (inclusive).

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP). 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 Plus SNP-DE H4007-026 (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Administración de Seguros de Salud (ASES) (Medicaid).

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Puerto Rico Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

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.

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

This *Evidence of Coverage* document tells you how to get your Medicare and Medicaid medical care and prescription drugs. 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 and the prescription drugs available to you as a member of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP).

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 Plus SNP-DE H4007-026 (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *Prescription Drug Guide* (*Formulary*), 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 Plus SNP-DE H4007-026 (HMO D-SNP) between January 1, 2025 and December 31, 2025.

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 Plus SNP-DE H4007-026 (HMO D-SNP) after December 31, 2025. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 2.3 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
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan, you must be eligible for both Medicare and Medicaid.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within six-month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible,

what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

Section 2.3 Here is the plan service area for Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 municipalities in Puerto Rico: Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Anasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamón, Cabo Rojo, Caguas, Camuy, Canovanas, Carolina, Catano, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerío, Corozal, Culebra, Dorado, Fajardo, Florida, Guánica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Lares, Las Marías, Las Piedras, Loiza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Penuelas, Ponce, Quebradillas, Río Grande, Rincón, Sabana Grande, Salinas, San Germán, San Juan, San Lorenzo, San Sebastián, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, Yauco Municipalities, PR.

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 2.4 U.S. Citizen or Lawful Presence

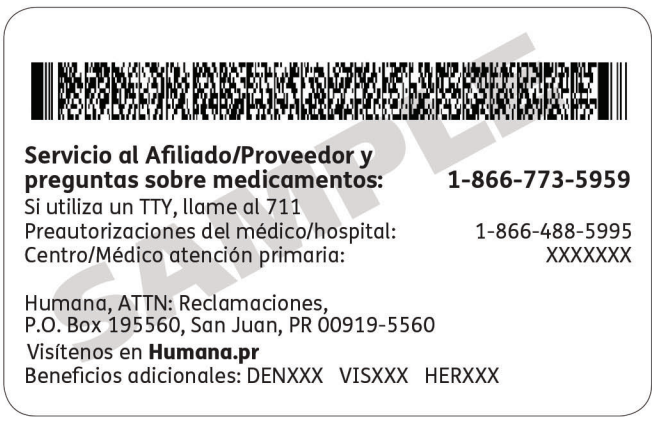
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) if you are not eligible to remain a member on this basis. Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 and for prescription drugs you get at network pharmacies. You should also show the provider your Administración de Seguros de Salud (ASES) (Medicaid) card. Here's a sample membership card to show you what yours will look like:

Humana.
HUMANA GOLD PLUS (HMO)
Un plan de salud de Medicare con cubierta de medicamentos recetados
TARJETA EMITIDA: MM/DD/YYYY
MEMBER NAME
ID afiliado: HXXXXXXXX
Plan (80840) 9140461101
RxBIN: XXXXXX
RxPCN: XXXXXXXX
RxGRP: XXXXX
Copagos
MÉDICO PRIMARIO: $XX
ESPECIALISTA: $XX
EMERGENCIA HOSPITALARIA: $XX
MedicareRx Prescription Drug Coverage
CMS XXXXX XXX
SAMPLE


Servicio al Afiliado/Proveedor y preguntas sobre medicamentos: 1-866-773-5959
Si utiliza un TTY, llame al 711
Preautorizaciones del médico/hospital: 1-866-488-5995
Centro/Médico atención primaria: XXXXXXX
Humana, ATTN: Reclamaciones,
P.O. Box 195560, San Juan, PR 00919-5560
Visítenos en **Humana.pr**
Beneficios adicionales: DENXXX VISXXX HERXXX
SAMPLE

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 Plus SNP-DE H4007-026 (HMO D-SNP) 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.

Be sure to show your Administración de Seguros de Salud (ASES) (Medicaid) ID card in addition to your Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) membership card to make your provider aware that you may have additional coverage.

Section 3.2 Provider Directory

The Provider Directory **(Humana.com/PlanDocuments**) lists our current network providers, durable medical equipment suppliers, and pharmacies. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in network), out-of-area dialysis services, and cases in which Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) authorizes use of out-of-network providers.

Contact your network provider(s) to verify the provider has registered with Puerto Rico Medicaid.

Many of the plan's network providers are also Medicaid certified. Contact your network provider(s) to verify the provider has registered with Puerto Rico Medicaid.

The *Provider Directory* (Humana.com/PlanDocuments) lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

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 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 and pharmacies.

Section 3.3 The plan's Prescription Drug Guide *(Formulary)*

The plan has a *Prescription Drug Guide* (*Formulary*). We call it the "Drug Guide" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) Drug Guide.

The Drug Guide also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug Guide. The Drug Guide we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug Guide. If one of your drugs is not listed in the Drug Guide, you should visit our website or contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website **(Humana.com/PlanDocuments)** or call Customer Care.

SECTION 4 Your monthly costs for Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Administración de Seguros de Salud (ASES) (Medicaid) as well as have both Medicare Part A and Medicare Part B.

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.

Medicare Part B Premium Reduction

Your Medicare Part B premium is automatically deducted from your monthly Social Security check. While you are enrolled in this plan, Humana will pay up to **$174.70** of your Medicare Part B premium. As a result, your monthly Social Security check will increase by this amount. You do not have to complete any paperwork to receive this benefit. We will take care of that for you.

It could take several months for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for several months after the effective date of this plan. Any missed increases will be added to your next check after processing is complete.

Please note that if you disenroll from this plan, your Medicare Part B premium benefit will end on the date of disenrollment. As mentioned above, it could take several months for the Social Security Administration to complete their processing. Any premium reductions you receive after you disenroll will eventually be deducted from your Social Security check.

Section 4.3 Part D Late Enrollment Penalty

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

You **will not** have to pay it if:

- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is **$36.78**.

- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times **$36.78**, which equals **$5.14**. This rounds to **$5.10**. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

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.

However, in some cases, you may need to start paying a late enrollment penalty.

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 including your Primary Care Provider.

The doctors, hospitals, pharmacists, 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 and drugs 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 and/or employer group health plans have paid.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 Plus SNP-DE H4007-026 (HMO D-SNP) Customer Care. We will be happy to help you.

Method	Customer Care – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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, and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 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	1-800-658-9928
WRITE	Humana P.O. Box 195560 San Juan, PR 00919-5560
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 or Part D prescription drugs. 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 or Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Coverage Decisions For Medical Care – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 30.

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.
WRITE	Humana P.O. Box 195560 San Juan, PR 00919-5560
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	Coverage Decisions for Part D prescription drugs – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 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.
FAX	1-855-681-8650 for coverage determinations only.
WRITE	Humana Clinical Pharmacy Review Attn: Medicare Part D Coverage Determinations P.O. Box 191920 San Juan, PR 00919-1920
WEBSITE	**Humana.com/member/member-rights/pharmacy-authorizations** Live chat available through **Humana.com**, Monday through Friday, 8 a.m. to 8 p.m., Eastern Standard Time.

Method	Appeals For Medical Care or Part D prescription drugs – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 30. For expedited appeals please call 1-866-773-5959.

Method	Appeals For Medical Care or Part D prescription drugs – 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	1-800-595-0462 for expedited appeals only.
WRITE	**Humana Grievances and Appeals Dept.** **P.O. Box 195560** **San Juan, PR 00919-5560**
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 or pharmacies, 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 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Method	Complaints about Medical Care – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 30. For expedited grievances please call 1-866-773-5959.
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	1-800-595-0462, for expedited grievances only.
WRITE	Humana Grievances and Appeals Dept. P.O. Box 195560 San Juan, PR 00919-5560
MEDICARE WEBSITE	You can submit a complaint about Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 our share of the cost for medical care or a drug 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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 - Sept. 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 195560 San Juan, PR 00919-5560
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.

Method	Medicare – Contact Information
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 Plus SNP-DE H4007-026 (HMO D-SNP): • **Tell Medicare about your complaint:** You can submit a complaint about Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 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.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

To be enrolled in this Dual Eligible Special Needs Plan, you must be enrolled in Medicare and also must receive certain levels of assistance from Administración de Seguros de Salud (ASES) (Medicaid). (See Chapter 1, Section 2.1 "Special eligibility requirements for our plan" for the specific requirements for this plan.)

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

If you have questions about the assistance you get from Medicaid, contact Administración de Seguros de Salud (ASES) (Medicaid). Contact information for Administración de Seguros de Salud (ASES) (Medicaid) can be found in "Exhibit A" in the back of this document.

The Office of the Ombudsmen of Puerto Rico, also known as the Office of the Citizen Advocate, helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	Office of the Ombudsman of Puerto Rico - Contact Information
CALL	(787) 724-7373
TTY	TTY: 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	(787) 724-8130

Method	Office of the Ombudsman of Puerto Rico - Contact Information
WRITE	Office of the Ombudsman Minillas Station P.O. Box 41088 San Juan, Puerto Rico 00940-1088 Email: ombudsmanpr@opc.pr.gov
WEBSITE	https://www.ombudsman.pr.gov/el-ombudsman

The Office of Aging helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Office of Aging – Contact Information
CALL	(787) 721-6121, ext. 1236
TTY	TTY: 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	(787) 721-2919
WRITE	Puerto Rico Governor's Office of Elder Affairs P.O. Box 50063 San Juan, PR 00902

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website **(https://www.medicare.gov/basics/costs/help/drug-costs)** provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

What if you have "Extra Help" and coverage from an AIDS Drug Assistance Program (ADAP)?
What is the 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 8 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.
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 9 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.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:
Using the plan for your medical and other covered services

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

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

For the details on what medical care and other services are 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 pay nothing or only your share of the cost for covered services. Contact your network provider to verify that they have registered with Puerto Rico Medicaid.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare and Medicaid health plan, Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare in the benefits chart in Chapter 4.

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions*:

  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.

  - If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You must obtain authorization from the plan prior to seeking care from an out-of-network provider. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan’s service area and obtain the dialysis from a provider that is outside the plan’s network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan’s network the cost sharing for the dialysis may be higher.

SECTION 2 Use providers in the plan's network to get your medical care and other services

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care

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

A "PCP" is your Primary Care Provider. When you become a member of the plan, you must choose a network doctor to be your PCP. Your PCP is a provider who meets state license requirements and is trained to give you basic medical care.

Having a PCP is an important step in managing your overall well-being. As the doctor who gets to know your medical history best, your PCP can provide you with routine healthcare and ongoing preventive care to keep you as healthy as possible. If you need to see specialists or get other services such as:

- X-Rays

- Lab Tests
- Physical Therapy
- Care from specialists
- Hospital admissions
- Follow-up care

You may need to get a referral from your PCP to a network specialist or other provider. Your PCP can help make sure all your care is coordinated, by checking with other network providers about your care. The only exceptions are the few covered services you can get from an in-network provider without a referral from your PCP. These are listed in Chapter 3, Section 2.2 below. In some cases, your PCP will need to get prior authorization (prior approval). Chapter 4 has more information on which services require prior authorization.

Just call your PCP to make an appointment when you need one. To help your PCP understand your medical history and oversee all your care, you may want to have your previous doctors send your past medical records to your new PCP.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs; however, there are a few types of covered services you may get on your own, without first contacting your PCP. See Chapter 3, Section 2.2 for more information.

If it is after normal business hours and you have a need for routine care, please call your PCP back during normal business hours. If you have an emergency or have an urgent need for care after normal business hours, see Sections 3.1 or 3.2 in this chapter.

How do you choose your PCP?

When you enrolled, you received a *Provider Directory* with a list of many PCPs in your area. If you need help finding or choosing one, call Customer Care or you can always see the most up-to-date list online at **Humana.com/findadoctor**. You will have to choose one of our network providers in your plan's service area listed in this document to be your Primary Care Provider (PCP).

To choose a PCP that's a good fit for you, call them to ask how long it usually takes to get an appointment and be sure the office hours are convenient for you. If there are particular network hospitals or specialists that you think you might want to use, you should also ask if the PCP uses them for referrals.

When you receive your Humana member ID card, the name and phone number of your PCP will be printed on it, so you always have it handy.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP call Customer Care. We'll make sure your new PCP is accepting new patients and then send you an updated member ID card. The change usually goes into effect on the first day of the month after you call.

Be sure to tell Customer Care if you're currently seeing specialists or any other providers that required a referral from your old PCP. We'll make sure you can continue with any services that had already been approved.

Section 2.2 What kinds of medical care and other services can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots (or vaccines), COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
  - After your emergency condition has stabilized, please verify your out-of-network emergency care provider(s) have registered with Puerto Rico Medicaid.
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
  - After your urgently needed services condition has stabilized, please verify your out-of-network urgently needed services provider(s) have registered with Puerto Rico Medicaid.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Customer Care before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
  - After your out-of-network kidney dialysis condition has stabilized, please verify your out-of-network kidney dialysis provider(s) have registered with Puerto Rico Medicaid.
- All covered preventive services from network providers. These services are indicated in the Chapter 4 Medical Benefits Chart with an
- Supplemental Benefits covered by the plan. These services are indicated in the Chapter 4 Medical Benefits Chart with an asterisk (*).

Treatment, and its related services, for special conditions listed below do not need a referral from the Primary Care Physician (PCP) once the diagnosis has been established.

HIV/AIDS, Tuberculosis, Leprosy, Systemic Lupus Erythematosus (SLE), Cystic Fibrosis, Cancer, Hemophilia, ESRD=> Levels 3, 4 and 5, Multiple Sclerosis & Amyotrophic Lateral Sclerosis (ALS), Scleroderma, Pulmonary Hypertension, Aplastic Anemia, Rheumatoid Arthritis, Autism, Skin cancer: carcinoma IN SITU, Skin cancer: Invasive Melanoma or squamous cells with evidence of metastasis, Adults with Phenylketonuria, Chronic Hepatitis C, Congestive Heart Failure (CHF) Class III and IV- NHHA in a potential candidate for heart transplant, Primary Ciliary Dyskinesia (PCD) / Immotile Ciliary Syndrome/ Syndrome de Kartagener, Inflammatory Bowel Disease (IBD): Crohn's disease; Ulcerative Colitis and Microscopic Colitis, Post -Transplant.

When a patient is referred to a specialist by a PCP and prescribes a medication, no countersignature of the prescription will be required from the PCP.

If the MAOs have contracted with Primary Medical Groups (PMGs), who have directly contracted preferred provider specialists, a referral from the PCP is not necessary when both are a part of the same PMG. However, the specialists will be obliged to inform the PCP about the medical services referred.

Patients can see specialists such as a Gynecologist/Obstetrician and Urologist, among others, without a referral from their PCP. Referrals for laboratory, diagnostic tests and others shall be governed by the referral requirements listed above.

No referral is required for services related to pathological laboratories.

Bioequivalent drugs are mandatory.

People aged 60 and over will be able to choose a Geriatrician as their PCP.

Section 2.3 How to get care from specialists and other network providers

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

Referrals

Remember, you may need a referral from your PCP to see a specialist. Even if you have a referral for one type of care from a specialist, you may need another referral from your PCP if a new service or treatment is added.

All in-network specialists are listed in the *Provider Directory*, which you can find at **Humana.com/findadoctor**. Keep in mind, just because providers are in-network doesn't mean that your PCP will provide referrals to all of them. You'll need to ask which hospitals and specialists your PCP uses for referrals.

For some types of services, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4, Section 2.1 for information about which services require prior authorization.

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

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 that are 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.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required for service to be covered.
- 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.

Section 2.4 How to get care from out-of-network providers

Your network PCP must give you approval in advance before you can use providers not in the plan's network. This is called giving you a "referral." For more information about this and situations when you can see an out-of-network provider without a referral (such as an emergency), see Sections 2.2 and 2.3 of this chapter. If you don't have a referral (approval in advance) before you get services from an out-of-network provider, you may have to pay for these services yourself.

Out-of-network providers must register with Puerto Rico Medicaid. Out-of-network providers can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid. If you receive services from an out-of-network provider that does not register with Puerto Rico Medicaid, you may have to pay for these services yourself.

Please ask an out-of-network provider to bill the plan for services that you believe we should cover. If the provider refuses to bill the plan and sends you a bill that you think we should pay, you can send it to us for payment to the provider. If the provider refuses to bill the plan and you pay the provider, we will reimburse you for our share of the cost for covered services. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

For some types of services, your doctor may need to get approval in advance from our plan (this is called getting "prior authorization"). See Chapter 4, Section 2.1 for more information about which services require prior authorization.

Note: You are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area and are not able to access contracted ESRD providers.

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

Section 3.1 Getting care if you have a medical emergency

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

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent 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. After your emergency condition has stabilized, please verify your emergency care provider(s) have registered with Puerto Rico Medicaid. Your provider can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. 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 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. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency

after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- *- or -* The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care, we will cover urgently needed services that you get from an out-of-network provider.

After your emergency condition has stabilized, please verify your out-of-network emergency care or urgently needed services provider(s) have registered with Puerto Rico Medicaid. Your out-of-network emergency or urgently needed care provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

The plan's *Provider Directory* will tell you which urgent care 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 (phone numbers are printed on the back cover of this document).

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

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 reimbursement from us. After your emergency condition has stabilized, please verify your out-of-network emergency care or urgently needed services provider(s) have registered with Puerto Rico Medicaid. Your out-of-network emergency or urgently needed care provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid. 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 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do if you receive a bill or if you need to ask for reimbursement.

Section 3.3 Getting care during a disaster

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

Please visit the following website: **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. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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 for 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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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.

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.

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 requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies 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. Please verify your Clinical Research study provider has registered with Puerto Rico Medicaid. Your Clinical Research Study provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and 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.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

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.
- Your Religious Non-Medical Institution must register with Puerto Rico Medicaid. Your Religious Non-Medical Institution can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

Medicare Inpatient Hospital coverage limits do not apply to inpatient psychiatric, behavioral health, or substance abuse services (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 that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP), 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 Plus SNP-DE H4007-026 (HMO D-SNP) 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 Plus SNP-DE H4007-026 (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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 Plus SNP-DE H4007-026 (HMO D-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. Also, see exclusions and limitations pertaining to certain supplemental benefits listed 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.

- **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.)

Section 1.2 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. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2025 this amount is **$3,400** (In-Network).

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amount you pay for your prescription drugs does not count toward your out-of-pocket maximum. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$3,400**, 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 your Medicare Part B premium (unless your Part B premium is paid for you by Administración de Seguros de Salud (ASES) (Medicaid) or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

As a member of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or outside the service area for urgently needed services.)
- If you believe a provider has balance billed you, call Customer Care.

If you are cost share protected by Administración de Seguros de Salud (ASES) (Medicaid), we do not allow in-network providers to bill you for covered services. We pay our in-network providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. If you receive a bill from a provider that you feel you should not pay, call 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 Plus SNP-DE H4007-026 (HMO D-SNP) 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 and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote.
    - > The preauthorization list can be found here: **Humana.com/PAL**
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* 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, plan cost-sharing will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.
- This plan includes both Medicare benefits and some Medicaid benefits which are not offered under Medicare. The Medical Benefits Chart below lists all of the Medicare benefits and the additional Medicaid benefits that are covered.
- If you are within our plan's six-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. Medicare cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

Be sure to show your Administración de Seguros de Salud (ASES) (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage.

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.**

+ You will see this plus sign next to the Medicaid covered services included in our plan. Your Medicaid Covered Services Providers must be registered with Puerto Rico Medicaid. Your Provider can contact Puerto Rico Medicaid at 787-641-4200 or go to medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

For a full list of Medicaid benefits offered through your state Medicaid program and cost-sharing requirements, if any, please see the Medicaid Benefit Comparison section of your Summary of Benefits. Please contact your Medicaid Agency for benefit eligibility and determining your level of cost-sharing responsibility.

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 nurse specialist.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 20 visits per calendar 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:** **$0** copayment – Specialist's Office
Allergy shots and serum You are covered for allergy shots and serum when medically necessary.	**In-Network:** Allergy Shots and Serum **$0** copayment – PCP's Office – Specialist's Office
Ambulance services	**In-Network:**

Services that are covered for you	What you must pay when you get these 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 endanger the person's health and that transportation by ambulance is medically required. Prior authorization requirements may apply.	Emergency Ambulance **$0** copayment per date of service regardless of the number of trips – Ground Ambulance – Air Ambulance Non-Emergency Ambulance **$0** 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.
*** Bathroom safety device** The plan will provide one (1) contracted standard bath or shower chair with or without wheels, any size every 5 years to members who meet the medical criteria. Prior authorization requirements may apply.	**In-Network:** **$0** copayment
*** Blood pressure monitor** The plan will provide one (1) blood pressure monitoring unit every 5 years to members who meet the medical criteria. Prior authorization requirements may apply.	**In-Network:** **$0** copayment
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.
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 age 40 and older • Clinical breast exams once every 24 months	
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 referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Prior authorization rules may apply.	**In-Network:** **$0** 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. Prior authorization requirements may apply.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
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.
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.
Chiropractic services Covered services include: • We cover manual manipulation of the spine to correct subluxation (one or more of the bones of your spine move out of position) *In addition to the Medicare Covered Benefit listed above, you may self-refer to a network chiropractor for 12 visits per calendar year for care. Covered supplemental services include: • New and established patient examinations • Select x-ray procedures	**In-Network:** Medicare Covered Chiropractic Services **$0** copayment – Specialist's Office **In-Network:** Chiropractic Services (Routine) **$0** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
• Extremity manipulation for joints other than the spine (e.g. shoulder, knee, ankle) • Select physical medicine modalities and procedures	
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-up 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.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, 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 **Mandatory Supplemental Dental Benefits** which include preventive and diagnostic services.	**In-Network:** Medicare Covered Dental Services **$0** copayment – Specialist's Office **Mandatory Supplemental Dental Benefits** *You are covered for Mandatory Supplemental Dental Benefit. See the **Mandatory Supplemental Dental Benefit** description at the end of this chart for details.
+ DENTAL SERVICES PREVENTIVE & RESTORATIVE (Medicaid Covered)	**In-Network:**

Services that are covered for you	What you must pay when you get these services
• All preventative and corrective services for children under age twenty-one (21) • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy. • Preventive dental services for adults. • Restorative dental services for adults. • One (1) comprehensive oral exam per year. • One (1) periodical exam every six months. • One (1) defined problem-limited oral exam. • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography. • Up to five (5) additional periapical/intra-oral radiographies per year. • One (1) single film-bite radiography per year. • One (1) two-film bite radiography per year. • One (1) panoramic radiography every three (3) years. • One (1) adult cleanses every six (6) months. • One (1) child cleanses every six (6) months. • One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old. • Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies. • Amalgam restoration; • Resin restorations; • Root Canal; • Palliative treatment; and • Oral Surgery • Sedation and anesthesia services for beneficiaries with physical or mental handicaps in compliance with local laws. • Periodontal Scaling and root planning up to 4 cuadrants per beneficiary. • Interim removable partial dentures (upper and lower). • Hospital visits. • All limitations may be exceeded based on medical necessity and approved thorough prior preauthorization or exemption process.	Dental Services Preventive & Restorative (Medicaid Covered) **$0** copayment • Specialist's Office See **Mandatory Supplemental Dental Benefit** information below this chart for information on dental services (Medicaid Covered) annual maximums, service frequency and limitations.
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.
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	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes

Services that are covered for you	What you must pay when you get these services
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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	screening tests.
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 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.	**In-Network:** Diabetes self-management training **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital Diabetic Monitoring Supplies **$0** copayment – Diabetic Supplier – Network Retail Pharmacy Diabetic Shoes and Inserts **$0** copayment – Durable Medical Equipment Provider – Prosthetics Provider
Durable medical equipment (DME) and related supplies	**In-Network:** Durable Medical Equipment **10%** coinsurance – Durable Medical Equipment

Services that are covered for you	What you must pay when you get these services
(For a definition of durable medical equipment, see Chapter 12 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**. Prior authorization requirements may apply. **Preferred Continuous Glucose Monitors (CGMs) are covered at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not covered through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically necessary. All CGMs will continue to be covered through durable medical equipment providers (DME).	Provider Continuous Glucose Monitor **10%** coinsurance – Durable Medical Equipment Provider **$0** copayment – Pharmacy
EKG screening The screening EKG, when done as a referral from the *Welcome to Medicare* preventive visit, is only covered once during a beneficiary's lifetime.	**In-Network:** There is no coinsurance, copayment, or deductible for an EKG screening visit.
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. After your emergency condition has stabilized, please verify your emergency care provider(s) have registered with Puerto Rico Medicaid. Your provider can contact Puerto	**In-Network:** Emergency Services **$0** copayment – Emergency Room **In-Network** Provider and Professional Services **$0** copayment – Emergency Room If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital

Services that are covered for you	What you must pay when you get these services
Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid. 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 proof of payment to Humana for reimbursement. After your emergency care world-wide coverage condition has stabilized, please verify your emergency care world-wide condition care provider(s) have registered with Puerto Rico Medicaid. Your provider can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid. For more information please see Chapter 7. 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.	authorized by the plan and your cost is the cost sharing you would pay at a network hospital.
+ FAMILY PLANNING (Medicaid Covered) Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations: • Contra-indication with drugs that the Enrollee is already taking, and no other methods covered/available that can be used by the Enrollee. • History of adverse reaction by the Enrollee to the contraceptive methods covered. • History of adverse reaction by the Enrollee to the contraceptive medications that are covered. **+ MATERNITY SERVICES (Medicaid Covered)** Abortions when the pregnancy is a result of rape or incest as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term as certified by a physician.	**In-Network:** Provider and Professional Services **$0** copayment • PCP's Office • Specialist's Office Telehealth Services **$0** copayment • PCP Virtual • Specialist Virtual Surgery Services **$0** copayment • PCP's Office • Specialist's Officet

Services that are covered for you	What you must pay when you get these services
+ MEDICAL AND SURGICAL (Medicaid Covered) Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form included as Appendix (O)(25) of the Contract.	
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 addition, we cover **Mandatory Supplemental Hearing Benefits** which include a routine hearing exam and hearing aid coverage.	**In-Network:** Medicare Covered Hearing Services **$0** copayment – Specialist's Office **Mandatory Supplemental Hearing Benefits** *You are covered for Mandatory Supplemental Hearing Benefit. See the **Mandatory Supplemental Hearing Benefit** description at the end of this chart for details.
+ HEARING EXAMS (Medicaid Covered) Hearing aids for beneficiaries over 20 years old are excluded from coverage.	**In-Network:** Hearing Exams (Medicaid Covered) **$0** copayment • Specialist's Office
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.
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 **10%** coinsurance – Durable Medical Equipment Provider

Services that are covered for you	What you must pay when you get these services
Prior authorization requirements may apply.	
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 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.	**In-Network:** Medical Supplies **$0** copayment – Medical Supply Provider Other Medicare Part B Drugs **$0** copayment – 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. Your hospice doctor can be a network provider or an out-of-network provider. 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 related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for 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	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 Plus SNP-DE H4007-026 (HMO D-SNP). 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
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 covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) but are not covered by Medicare Part A or B: Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
*** Humana Well Dine® 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 nutritious 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 Customer Service number on the back of your Humana Member ID card.	**In-Network:** There is no coinsurance, copayment, or deductible to participate.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines	**In-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services
• Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit. Refer to Chapter 5, Section 12 for additional information.	
+ PREVENTIVE SERVICES (Medicaid Covered) Immunization services non-covered by; 1. Medicare Part B. 2. MAO Part D drug formulary. 3. MAO supplementary plan benefits. 4. Not covered by the Puerto Rico Department of Health Immunization Program, but included in the Puerto Rico Medicaid State Plan. **1. Vaccines for children from 0-20 years of age (inclusive)** • Hepatits A • Hepatitis B • Rotavirus (RV) • DTaP (Toxoides de Diphtheria y vacuna pertussis acelular) • Hib (Vacuna conjugada Hib) • PCV 15 PCV13 Y PPSV23 (Vacunas antineumocócicas) • Polio (IPV) • Vacunas contra la influenza (Virus atenuado LAIV o la IIV). • MMR • Varicela (VAR) • Vacunas Antimeningocócicas - MenACWY-D [Menactra], MenACWY-CRM (Menveo) MenB (Meningeococos serogrupo B Men B -4C [Bexserol] y Men B- FHbp [Trumenba] • Tdap • Virus Papiloma Humano (VPH) • Dengvaxia (Indicated for the prevention of dengue disease caused by dengue virus serotypes 1, 2, 3 and 4. is approved for use in individuals 9 through 16 years of age with laboratory-confirmed previous dengue infection and living in endemic areas. **COVID 19** **2. Vaccines for adults from 21 years of age** Haemophilus influenzae type b vaccine – **Hib** Hepatitis A vaccine – **HepA** Hepatitis A and hepatitis B vaccine - **HepA-HepB** Hepatitis B vaccine – **HepB** Human papillomavirus vaccine – **HPV** Influenza vaccine (inactivated) - **IIV4** Influenza vaccine (live, attenuated) - **LAIV4** Influenza vaccine (recombinant) - **RIV4** Measles, mumps, and rubella vaccine – **MMR**	**In-Network:** There is no coinsurance, copayment, or deductible for Preventive Services (Medicaid Covered).

Services that are covered for you	What you must pay when you get these services
Meningococcal serogroups A, C, W, Y vaccine **MenACWY-D** **MenACWY-CRM** **MenACWY-TT** Meningococcal serogroup B vaccine **MenB-4C** **MenB-FHbp** Pneumococcal 15-valent conjugate vaccine - **PCV15** Pneumococcal 20-valent conjugate vaccine - **PCV20** Pneumococcal 23-valent polysaccharide vaccine - **PPSV23** Tetanus and diphtheria toxoids – **Td** Tetanus and diphtheria toxoids and acellular pertussis vaccine – **Tdap** Varicella vaccine – **VAR** Zoster vaccine, recombinant - **RZV** 3. **Post-transplanted bone marrow patients of <u>any age</u> will be covered for all required vaccinations.** 4. **COVID 19 Vaccine** - not included in the Medicaid Wrap Around but are provided by the Department of Health (DOH).	
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 use disorder 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. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community	**<u>In-Network:</u>** <u>Inpatient Care</u> **$0** copayment per admission – Inpatient Hospital If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. **<u>In-Network</u>** <u>Provider and Professional Services</u> **$0** copayment – Inpatient Hospital

Services that are covered for you	What you must pay when you get these services
pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel and lodging reimbursement requires a minimum of 100 miles one way to transplant center and is limited to **$10,000** per 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. Additional details on transplant travel and lodging can be found at **https://provider.humana.com/patient-care/transplant-resources/transplant-services-questions** • 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. 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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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. Prior authorization is required for inpatient hospital care. Prior authorization is required for transplant services.	
+ INPATIENT HOSPITAL SERVICES (Medicaid Covered) Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). Coverage includes: • Isolation room for medical reasons. • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized.	**In-Network:** Inpatient Hospital Services (Medicaid Services) **$0** copayment per admission – Inpatient Hospital Provider and Professional Services **$0** copayment – Inpatient Hospital

Services that are covered for you	What you must pay when you get these services
• Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy. Blood: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated complex (Auto flex and Feiba) per authorization of a certified hematologist.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Prior authorization is required for inpatient mental health care.	**In-Network:** Inpatient Mental Health Care **$0** copayment per admission – Inpatient Hospital – Inpatient Psychiatric Facility **In-Network** Provider and Professional Services **$0** copayment – Inpatient Hospital – Inpatient Psychiatric Facility
+ INPATIENT HOSPITAL FOR MENTAL HEALTH DISEASES (Medicaid Covered) Access to semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year). **+ INPATIENT SUBSTANCE USE DISORDER (Medicaid Covered)** Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year).	**In-Network:** Inpatient Mental Health Care **$0** copayment per admission – 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, but are not limited to: • 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	When your inpatient stay is not covered, you will pay the cost of the services received as described throughout this benefit chart.

Services that are covered for you	What you must pay when you get these services
• 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 Prior authorization requirements may apply.	
+ LABORATORY AND HIGH-TECH LABORATORIES (Medicaid Covered) Health Certificates are covered under the GHP, provided that cost sharing and/or deductibles applicable for necessary procedures and laboratory testing related to generating a Health Certificate will be the Enrollee's responsibility. Such certificates shall include: • Venereal Disease Research Laboratory("VDRL") tests. • Tuberculosis ("TB") tests; and • Any Certification for GHP Enrollees related to eligibility for the Medicaid Program (provided at no charge).	**In-Network:** There is no coinsurance, copayment, or deductible for Laboratory and High-Tech Laboratories (Medicaid Covered).
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred 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 referral. A physician must prescribe these services and renew their referral 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.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. 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.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs	**In-Network:** Chemotherapy Drugs **$0** copayment

Services that are covered for you	What you must pay when you get these services
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 • The Alzheimer's drug, Leqembi ®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this	– Specialist's Office – Outpatient Hospital Medicare Part B Insulin Drugs **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy Other Medicare Part B Drugs **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Pharmacy 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."

Services that are covered for you	What you must pay when you get these services
drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) 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 and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. Prior authorization requirements may apply.	
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.
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 disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital – 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	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office – Specialist's Office Diagnostic Procedures and Tests **$0** copayment – PCP's Office

Services that are covered for you	What you must pay when you get these services
• 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 Prior authorization requirements may apply.	– Specialist's Office – Urgent Care Center – Outpatient Hospital <u>Advanced Imaging Services</u> **$0** copayment – PCP's Office – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility <u>Basic Radiological Services</u> **$0** copayment – PCP's Office – Specialist's Office – Urgent Care Center – Outpatient Hospital – Freestanding Radiological Facility <u>Diagnostic Mammography</u> **$0** copayment – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility <u>Radiation Therapy</u> **$0** copayment – Specialist's Office – Outpatient Hospital – Freestanding Radiological Facility <u>Nuclear Medicine Services</u> **$0** copayment – Outpatient Hospital – Freestanding Radiological Facility <u>Facility Based Sleep Study</u> **$0** copayment – Specialist's Office – Outpatient Hospital <u>Home Based Sleep Study</u>

Services that are covered for you	What you must pay when you get these services
	$0 copayment – Member's Home Medical Supplies **$0** copayment – Medical Supply Provider Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital Lab Services **$0** copayment – PCP's Office – Specialist's Office – Urgent Care Center – Outpatient Hospital – Freestanding Laboratory
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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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. Prior authorization requirements may apply.	**In-Network:** **$0** copayment – Outpatient Hospital
Outpatient hospital services	**In-Network:**

Services that are covered for you	What you must pay when you get these 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 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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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. Prior authorization requirements may apply.	Diagnostic Procedures and Tests **$0** copayment – Outpatient Hospital Advanced Imaging Services **$0** copayment – Outpatient Hospital Nuclear Medicine Services **$0** copayment – Outpatient Hospital Basic Radiological Services **$0** copayment – Outpatient Hospital Diagnostic Mammography **$0** copayment – Outpatient Hospital Radiation Therapy **$0** copayment – Outpatient Hospital Lab Services **$0** copayment – Outpatient Hospital Surgery Services **$0** copayment – Outpatient Hospital Mental Health Services **$0** copayment – Outpatient Hospital – Partial Hospitalization Wound Care **$0** copayment – Outpatient Hospital Facility Based Sleep Study **$0** copayment – Outpatient Hospital Emergency Services **$0** copayment

Services that are covered for you	What you must pay when you get these services
	– Emergency Room Diagnostic Colonoscopy **$0** copayment – Outpatient Hospital
Outpatient mental health care 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.	**In-Network:** Mental Health Services **$0** copayment – Specialist's Office – Outpatient Hospital – Partial Hospitalization
+ OUTPATIENT MENTAL HEALTHCARE & PROFESSIONAL SERVICES (Medicaid covered) All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention.	**In-Network:** Mental Health Services **$0** copayment – Specialist's Office – Outpatient Hospital – 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 **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility Speech Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility Occupational Therapy **$0** copayment – Specialist's Office – Outpatient Hospital – Comprehensive Outpatient Rehab Facility
Outpatient substance use disorder services You are covered for treatment of substance abuse, as covered by Original Medicare.	**In-Network:** Outpatient Substance Use Disorder **$0** copayment – Specialist's Office

Services that are covered for you	What you must pay when you get these services
	– Outpatient Hospital – Partial Hospitalization
+ OUTPATIENT SUBSTANCE USE DISORDER (Medicaid Covered) Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.	**In-Network:** Outpatient Substance Use Disorder **$0** copayment – Specialist's Office – Outpatient Hospital – 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*. Prior authorization requirements may apply.	**In-Network:** Surgery Services **$0** copayment – Outpatient Hospital – Ambulatory Surgical Center Diagnostic Colonoscopy **$0** copayment – Ambulatory Surgical Center – Outpatient Hospital
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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor'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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. Prior authorization requirements may apply.	**In-Network:** Mental Health Services **$0** copayment – Partial Hospitalization
+ PRESCRIPTION DRUGS (Medicaid Covered) Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State Plan. The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings:	**In-Network:** Prescription Drugs (Medicaid Covered) **$0** copayment

Services that are covered for you	What you must pay when you get these services
• All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution. • Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drugs is covered by the GHP Formulary, the drug will be covered under Wrap-Around. The prescriber physician needs to exhaust available MAO formulary on the needed drug category. • Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.	
*** 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 calendar 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:** Routine Physical Exams **$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 PCP or 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 • 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	**In-Network:** Provider and Professional Services **$0** copayment – PCP's Office – Specialist's Office Telehealth Services **$0** copayment – PCP Virtual – Specialist Virtual – Mental Health Care and Substance Abuse Treatment Virtual – Urgent Care Virtual Advanced Imaging Services **$0** copayment – PCP's Office – Specialist's Office Surgery Services **$0** copayment – PCP's Office

Services that are covered for you	What you must pay when you get these services
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) • Physician/practitioner urgently needed services furnished in an office setting	– Specialist's Office Radiation Therapy **$0** copayment – Specialist's Office Urgently Needed Services **$0** copayment – PCP's Office – 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 **$0** copayment – Specialist's Office
Prostate cancer screening exams	**In-Network:** There is no coinsurance, copayment, or deductible for an

Services that are covered for you	What you must pay when you get these services
For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	annual PSA test.
Prosthetic and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail. Prior authorization requirements may apply.	**In-Network:** **10%** 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 a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Prior authorization requirements may apply.	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. 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.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
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 an 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	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an 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.	
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.
Services to treat kidney disease Covered services include: • 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.** Prior authorization requirements may apply.	**In-Network:** Kidney Disease Education Services **$0** copayment – PCP's Office – Specialist's Office Renal Dialysis Services **$0** copayment – Dialysis Center – Outpatient Hospital Durable Medical Equipment **10%** coinsurance – Durable Medical Equipment Provider Home Health Care **$0** copayment – Member's Home

Services that are covered for you	What you must pay when you get these services
*** 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. Any fitness center services that usually have an extra fee are not included in your membership.	**In-Network:** **$0** copayment
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 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 Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital Prior authorization requirements may apply.	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:** Skilled Nursing Care **$0** copayment per admission – Skilled Nursing Facility
Smoking and tobacco use cessation (counseling to stop smoking or	**In-Network:**

Services that are covered for you	What you must pay when you get these services
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
*** Smoking cessation program** To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This additional counseling attempt includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.	**In-Network:** **$0** copayment
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: • 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. Prior authorization requirements may apply.	**In-Network:** **$0** copayment – Specialist's Office – Outpatient Hospital
+ TOBACCO CESSATION (Medicaid Covered) Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.	**In-Network:** (Tobacco Cessation (Medicaid Covered) **$0** copayment

Services that are covered for you	What you must pay when you get these services
*** Transportation** You are covered for 36 one-way, non-emergency trips to plan-approved locations within the plan service area per calendar year. Coordination must be made Monday to Friday within 72 hours before the time services are needed. 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. Prior authorization may apply.	**In-Network:** **$0** copayment
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. • After your Urgently Needed Care condition has stabilized, please verify your out of network urgently needed services provider(s) have registered with Puerto Rico Medicaid. Your out of network urgently needed care provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid. 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 Customer Care for reimbursement. For more information please see Chapter 7. 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.After your worldwide emergency coverage condition has stabilized, please verify your worldwide emergency condition care provider(s) have registered with Puerto Rico Medicaid. Your provider can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.	**In-Network:** Urgently Needed Services **$0** copayment – Urgent Care Center

Services that are covered for you	What you must pay when you get these services
See **Physician/Practitioner services, including doctor's office visits** for additional information about urgently needed services provided in the office setting.	
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) In addition, we cover **Mandatory Supplemental Vision Benefits** which include a routine vision exam and an allowance for eyewear. The (preventive service) only applies to Glaucoma Screening. Prior authorization requirements may apply.	**In-Network:** Medicare Covered Vision Services **$0** 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 **Mandatory Supplemental Vision Benefits** *You are covered for Mandatory Supplemental Vision Benefit. See the **Mandatory 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.
+ VISION SERVICES (Medicaid Covered) Eyeglasses or lenses for beneficiaries between the ages of 0 to >21 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lenses have to be preauthorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.	**In-Network:** **$0** copayment
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	**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
the preventive services you need (including certain screenings and shots (or vaccines)), 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.	Welcome to Medicare preventive visit.

Mandatory Supplemental Dental Benefit DEN545

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

Deductible	**$0**
Annual Maximum (Annual maximum only applies to adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits. *Implant services and implant supported prosthetics only covered up to $2,000 annual maximum.)	**$3,500***

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%**	**100%**
Professional consultation	**0%**	**100%**
Diagnostic Services – Frequency/Limitations – 1 procedure code every 3 calendar years		
Comprehensive oral evaluation	**0%**	**100%**
Bitewing X-rays – Frequency/Limitations – 1 set per calendar year		
Bitewing x-rays	**0%**	**100%**
Intraoral X-rays (inside the mouth)– Frequency/Limitations – 6 procedure codes per calendar year		
Periapical x-rays	**0%**	**100%**
Occlusal x-rays	**0%**	**100%**
Panoramic X-rays – Frequency/Limitations – 1 procedure code every 3 calendar years		
Panoramic film	**0%**	**100%**
Prophylaxis (Cleaning) – Frequency/Limitations – 2 procedure codes per calendar year		
Prophylaxis (cleaning)	**0%**	**100%**

Description of Benefit	In-Network You Pay*	Out-of-Network You Pay
Periodontal Maintenance – Frequency/Limitations – 2 procedure codes per calendar year		
Periodontal maintenance following periodontal therapy	**0%**	**100%**
Comprehensive Services		
Restorations (Fillings) – Amalgam or Composite – Frequency/Limitations – 1 procedure code per tooth every 3 calendar years		
Amalgam (silver) – primary or permanent	**0%**	**100%**
Resin-based composite (white) – anterior (front) or posterior (back)	**0%**	**100%**
Extractions (Pulling Teeth) – Frequency/Limitations – Unlimited procedure codes per calendar year		
Extraction, erupted tooth, or exposed root	**0%**	**100%**
Restorative (Other Services) – Core Buildup or Prefabricated Post and Core – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Core buildup	**0%**	**100%**
Prefabricated post and core	**0%**	**100%**
Scaling and Root Planing – Frequency/Limitations – 1 procedure code per calendar year, per quadrant		
Periodontal scaling and root planing	**0%**	**100%**
Periodontal Debridement – Frequency/Limitations – 1 procedure code per calendar year		
Full mouth debridement to enable comprehensive evaluation and diagnosis	**0%**	**100%**
Root Canal – Frequency/Limitations – Unlimited procedure codes per calendar year		
Root canal	**0%**	**100%**
Crowns – Frequency/Limitations – 1 procedure code per tooth every 5 calendar years		
Crowns (not retainer crowns)	**0%**	**100%**
Onlay	**0%**	**100%**
Inlay – alternate benefit only	**0%**	**100%**
Bridges – Frequency/Limitations – 1 procedure code every 5 calendar years		
Pontic and retainer crown	**0%**	**100%**
Complete Dentures – Frequency/Limitations – 1 upper and lower complete or 1 upper and lower immediate denture every 5 calendar years, including routine post delivery care		
Complete denture – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Immediate denture – maxillary (upper) or mandibular (lower)	**0%**	**100%**
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%**	**100%**
Unilateral partial denture	**0%**	**100%**
Partial denture – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Removable unilateral partial denture	**0%**	**100%**

Description of Benefit	In-Network You Pay*	Out-of-Network You Pay
Periodontal Surgery – Frequency/Limitations – 1 procedure code every 3 calendar years, per quadrant		
Periodontal surgery	**0%**	**100%**
Denture Adjustments (not covered if within six months of initial placement) – Frequency/Limitations – Unlimited procedure codes per calendar year		
Complete denture adjustment– maxillary (upper) or mandibular (lower)	**0%**	**100%**
Partial denture adjustment – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Denture Reline – Frequency/Limitations – 1 procedure code every 5 calendar years		
Reline complete denture – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Reline partial denture – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Denture Repairs – Frequency/Limitations – 3 procedure codes per calendar year		
Repair complete denture base – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Repair partial denture base – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Repair partial denture framework – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Replace missing or broken tooth	**0%**	**100%**
Add tooth or clasp to partial denture	**0%**	**100%**
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower)	**0%**	**100%**
Implant Services – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Implant services	**0%**	**100%**
Implant Supported Prosthetics – Frequency/Limitations – 1 procedure code per tooth every 5 years		
Implant supported prosthetics	**0%**	**100%**
Cone Beam CT Imaging – Frequency/Limitations – 1 procedure code every 3 calendar years		
Cone beam CT imaging	**0%**	**100%**
Pulp Vitality Test – Frequency/Limitations – 2 procedure codes per calendar year, per quadrant		
Pulp vitality test	**0%**	**100%**

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.

*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 any applicable coinsurance payment still applies).

The provider locator can be found at **Humana.com** > Find care.

Mandatory Supplemental Hearing Benefit HER865

Coverage Description
You may receive the following non-Medicare covered services from any network hearing or hearing aid provider:

Description of Benefit	You Pay
Routine hearing exam (1 per year)	**$0**
Hearing aid fitting/evaluation (1 per year)	**$0**
Prescription hearing aid(s) or OTC hearing aids (1 per ear per year)	Any amount over **$1,000** per ear per year

The provider locator for routine hearing can be found at **Humana.com** > Find care.

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.

Mandatory Supplemental Vision Benefit VIS316

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

Description of Benefit	In-Network You Pay
• Routine Eye Exam (includes refraction) (1per calendar year)	**$0***
• Frames and Lens Package You have a choice of: – **$500** Benefit toward the purchase and fitting of eyeglasses and pair of lenses and/or purchase of contact lenses Contact lenses will include conventional or disposable. Ultraviolet protection and scratch-resistant coating are included in the eyeglass allowance benefit. Any remaining benefit dollars "roll over" to a future purchase within the same calendar year.	Any amount over **$500**

The provider locator for routine or Medicare-covered vision can be found at **Humana.com** > Find care.

*Your routine exam charge will not exceed **$0** at a network optical provider. Please inform the network provider that you are a member of Humana's plan.

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.

SECTION 3 What services are covered outside Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)?

Section 3.1 Services *not* covered by Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)

All services covered by Original Medicare are also covered by our plan.

SECTION 4 What services are not covered by the plan?

Section 4.1 Services *not* covered by the plan (exclusions)

This section tells you what services are excluded. In some cases, we cover items or services that are excluded by Medicare under our plan's Medicaid benefits. For more information about Administración de Seguros de Salud (ASES) (Medicaid) benefits, call Customer Care.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan 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 9, Section 6.3 in this booklet.)

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.
Charges for equipment which is primarily and customarily used for a nonmedical purpose, even though the item has some remote medically related use.	**Not covered under any condition**	
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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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**	
Nonconventional interocular lenses (IOLs) following cataract surgery, including • an astigmatism correcting function of an intraocular lens • a presbyopia correcting function of an intraocular lens	**Not covered under any condition**	
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 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**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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 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 Medical 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 a 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).
- Services received from an out-of-network dentist are not covered benefits.
- This plan covers additional Platino benefits. Limitations can change. See the Medical Benefits Chart earlier in this chapter for additional dental services information.
- 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.
- Any fees for any services rendered by a non-network hearing aid provider. In-network hearing aid providers reserve the right to only service devices purchased from in-network providers.
- Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds (except when covered under Medicaid), hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries (beyond the covered limit).

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

- Any benefits received at a non-network optical provider.
- 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:

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs may be covered for you under your Medicaid benefits. The correct and complete information on what Medicaid covered drugs are and are not covered by the plan is shown in the Chapter 4 *(Medical Benefit Chart (what is covered and what you pay))*.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter. *Or you can fill your prescription through the plan's mail-order service*.)
- Your drug must be in the plan's *Prescription Drug Guide* (*Formulary*) (we call it the Drug Guide for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)
- For Medicaid covered drugs, your prescriber must be registered with be registered with Puerto Rico Medicaid. Your prescriber can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are in the plan's Drug Guide.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider Directory*, visit our website (**Humana.com/PlanDocuments**), and/or call Customer Care.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Care or use the *Provider Directory*. You can also find information on our website at **Humana.com/PlanDocuments**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Provider Directory* (**Humana.com/PlanDocuments**) or call Customer Care.

Section 2.3 Using the plan's mail-order service

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

Our plan's mail-order service allows you to order **up to a 90-day supply.**

To get order forms and information about filling your prescriptions by mail, please contact Customer Care.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 business days from when your prescriptions are received. When you plan to use a mail-order pharmacy, it's a good precaution to ask your doctor to write two prescriptions for your drugs: one you'll send for ordering by mail, and one you can fill in person at an in-network pharmacy if your mail order doesn't arrive on time. That way, you won't have a gap in your medication if your mail order is delayed. If you have trouble filling your prescription at an in-network pharmacy while waiting for mail order, please contact your prescriber's office.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

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

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

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

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 14 business days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Customer Care.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an *extended supply*) of maintenance drugs in our plan's Drug Guide. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* (**Humana.com/PlanDocuments**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Care** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **If you need a prescription because of a medical emergency**
  - We will cover prescriptions that are filled at an out-of-network pharmacy (up to a 30-day supply) if the prescriptions are related to care for a medical emergency. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a prescription drug claim form, located at **https://www.humana.com/pharmacy/prescription-coverages/medicare-claim-forms/.** If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)
- **If you need coverage while you are traveling away from the plan's service area**
  - Both your prescriber and your pharmacy must register with Puerto Rico Medicaid. Your provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.
  - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our prescription mail-order service or through a network retail pharmacy that offers an extended supply. If you are traveling outside of your plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call Customer Care to find a network pharmacy in your area where you can fill your prescription. If a network pharmacy is not available, we will cover prescriptions that are filled at an out-of-network pharmacy (up to a 30-day supply) if you follow all other coverage rules identified within this document. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription.
  - **If the prescription is covered, it will be covered at an out-of-network rate.** You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you by submitting a paper claim form. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)
  - **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency, for example on a cruise ship when outside of the United States.**

There are other times you can get your prescription covered if you go to an out-of-network pharmacy.

These situations will be covered at an out-of-network rate. In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If you go to an out-of-network pharmacy or provider, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2 explains how to ask the plan to pay you back.) We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- You can't get a covered drug that you need immediately because there are no open in-network pharmacies within a reasonable driving distance.
- Your prescription is for a specialty drug in-network pharmacies don't usually keep in stock.
- You were eligible for Medicaid at the time you got the prescription, even if you weren't enrolled yet. This is called retroactive enrollment.
- You're evacuated from your home because of a state, federal, or public health emergency and don't have access to an in-network pharmacy.
- If you get a covered prescription drug from an institutional based pharmacy while a patient in an emergency room, provider based clinic, outpatient surgery clinic, or other outpatient setting.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2 explains how to ask the plan to pay you back.) Please verify your provider(s) have registered with Puerto Rico Medicaid. Your provider(s) can contact Puerto Rico Medicaid at 787-641-4200 or medicaid.pr.gov/Home/PEP to register with Puerto Rico Medicaid.

SECTION 3 Your drugs need to be in the plan's Drug Guide

Section 3.1 The Drug Guide tells which Part D drugs are covered

The plan has a *Prescription Drug Guide* (*Formulary*). In this *Evidence of Coverage*, **we call it the Drug Guide for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug Guide includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs may be covered for you under your Medicaid benefits. The correct and complete information on what Medicaid covered drugs are and are not covered by the plan is shown in the Chapter 4 *(Medical Benefit Chart (what is covered and what you pay)).* For information about prescription drugs covered only by Medicaid, contact Administración de Seguros de Salud (ASES) (Medicaid) at the phone number in "Exhibit A" of this document. Call Customer Care for more information on your Medicaid coverage (phone numbers are printed on the back cover of this document).

We will generally cover a drug in the plan's Drug Guide as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug Guide includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug Guide, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 12 for definitions of the types of drugs that may be on the Drug Guide.

Medicaid Covered Over-the-Counter Drugs

Our plan also covers certain Medicaid covered over-the-counter drugs used for smoking cessation. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Care.

What is *not* in the Drug Guide?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information about this, see Section 7.1 in this chapter.)
- In other cases, we have decided not to include a particular drug in the Drug Guide. In some cases, you may be able to obtain a drug that is not in the Drug Guide. (For more information, please see Chapter 9.)

Section 3.2 How can you find out if a specific drug is in the Drug Guide?

You have four ways to find out:

1. Check the most recent Drug Guide we provided electronically. (Please note: The Drug Guide we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug Guide. If one of your drugs is not listed in the Drug Guide, you should visit our website or contact Customer Care to find out if we cover it.)

2. Visit the plan's website (**Humana.com/PlanDocuments**). The Drug Guide on the website is always the most current.
3. Call Customer Care to find out if a particular drug is in the plan's Drug Guide or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (by visiting **Humana.com** and logging into MyHumana or by calling Customer Care). With this tool you can search for drugs on the Drug Guide to see an estimate of what you will pay and if there are alternative drugs on the Drug Guide that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug Guide.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our Drug Guide. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your healthcare provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Care to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you (See Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not in the Drug Guide or if your drug is restricted, go to Section 5.2 to learn what you can do.**

Section 5.2 What can you do if your drug is not in the Drug Guide or if the drug is restricted in some way?

If your drug is not in the Drug Guide or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an **exception** and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. The temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you have been taking **must no longer be in the plan's Drug Guide** OR **is now restricted in some way.**

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be

filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- **Transition Supply for Current Members with changes in treatment setting:**

  If the setting where you receive treatment changes during the plan year, you may need a short-term supply of your drugs during the transition. For example:

  – You're discharged from a hospital or skilled nursing facility (where your Medicare Part A payments include drug costs) and need a prescription from a pharmacy to continue taking a drug at home (using your Part D plan benefit); or

  – You transfer from one skilled nursing facility to another.

  If you do change treatment settings and need to fill a prescription at a pharmacy, we'll cover up to a 31-day supply of a drug covered by Medicare Part D, so your drug treatment won't be interrupted.

  If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization for continued coverage of your drug.

Policies for Temporary Drug Supplies During the Transition Period

We consider the first 90 days of the 2025 plan year a transition period if you're a new member, you changed plans, or there were changes in your drug coverage. As described above, there are several ways we make sure you can get a temporary supply of your drugs, if needed, during the transition period.

During the first 90 days, you can get a temporary supply if you have a current prescription for a drug that's not in our Drug Guide or requires prior authorization because of restrictions. The conditions for getting a temporary supply are described below.

<u>One-Time Transition Supply at a Retail or Mail-Order Pharmacy</u>

We'll cover up to a 30-day supply of a drug covered by Medicare Part D. While you have your temporary supply, talk to your doctor about what to do after you use the temporary supply. You may be able to switch to a covered drug that would work just as well for you. You and your doctor can request an exception if you believe it's medically necessary to continue the same drug.

<u>Transition Supply if you're in a Long-Term Care Facility</u>

We'll cover up to a 31-day supply of a drug covered by Medicare Part D. This coverage is available anytime during the 90 day transition period, as long as your current prescription is filled at a pharmacy in a long-term care facility.

If you have a problem getting a prescribed drug later in the plan year (after the 90 day transition period), we'll cover up to a 31-day emergency supply of a drug covered by Medicare Part D. The emergency supply will let you continue your drug treatment while you and your doctor request an exception or prior authorization to continue.

Transition Period Extension

If you have requested an exception or made an appeal for drug coverage, it may be possible to extend the temporary transition period while we're processing your request. Call Customer Care (phone numbers are printed on the back cover of this document) if you believe we need to extend the transition period to make sure you continue to receive your drugs as needed.

Costs for Temporary Supplies

Your copayment or coinsurance for a temporary drug supply will be based on your plan's approved drug cost-sharing.

For questions about a temporary supply, call Customer Care.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1. You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2. You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not in the plan's Drug Guide. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug Guide can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the "Drug Guide." For example, the plan might:

- **Add or remove drugs from the Drug Guide**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**

- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's Drug Guide.

See Chapter 12 for definitions of the drug types discussed in this chapter.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug Guide occur, we post information on our website about those changes. We also update our online Drug Guide regularly. This section describes the types of changes we may make to the Drug Guide and when you will get direct notice if changes were made for a drug that you are taking.

Changes we may make to the Drug Guide that affect you during the current plan year

- **Adding new drugs to the Drug Guide and immediately removing or making changes to a like drug in the Drug Guide.**
  - When adding a new version of a drug to the Drug Guide, we may immediately remove a like drug from the Drug Guide, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug Guide.
  - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug Guide and removing or making changes to a like drug in the Drug Guide with advance notice.**
  - When adding another version of a drug to the Drug Guide, we may remove a like drug from the Drug Guide, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug Guide.
  - We will tell you at least 30 days before we make the change, or tell you about the change and cover an 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs in the Drug Guide that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug Guide. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs in the Drug Guide.**

- We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For information on how to ask for a coverage decision, including an exception, see Chapter 9.

Changes to the Drug Guide that do not affect you during the current plan year

We may make certain changes to the Drug Guide that are not described above. In these cases, the changes will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug
- We remove your drug from the Drug Guide

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug Guide for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are **excluded.** This means neither Medicare nor Administración de Seguros de Salud (ASES) (Medicaid) pays for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX

Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs listed below are not covered by Medicare or Medicaid.

- Non-prescription drugs (also called over-the-counter drugs) - Your Plan may cover additional Platino Smoking Cessation over-the-counter drugs. Please see Chapter 4 *(Medical Benefits Chart (what is covered and what you pay))* for more information about this benefit.
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide both your plan membership information and your Administración de Seguros de Salud (ASES) (Medicaid) membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

Be sure to show your Administración de Seguros de Salud (ASES) (Medicaid) ID card in addition to your Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) membership card to make your provider aware that you may have additional coverage.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you**. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your *Provider Directory* (**Humana.com/PlanDocuments**) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Care. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not in our Drug Guide or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g.,anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure our members safely use prescription opioid and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to an appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with complex health needs. One program is called Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other healthcare providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about these programs, please contact Customer Care.

SECTION 11 We send you reports that explain payments for your drugs and which payment stage you are in

Section 11.1 We send you a monthly summary called the *SmartSummary*

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket** cost.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *SmartSummary. The SmartSummary* includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 11.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program

– Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances

If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the *SmartSummary* look it over to be sure the information is complete and correct. If you think something is missing, or you have any questions, please call us at Customer Care. Be sure to keep these reports.

SECTION 12 The Plan Covers Additional Platino Benefits

The Plan Covers Additional Platino Benefits:

Your plan covers the following vaccinations:

1. Vaccines for children from 0-20 years of age (inclusive)

- Hepatits A
- Hepatitis B
- Rotavirus (RV)
- DTaP (Toxoides de Diphtheria y vacuna pertussis acelular)
- Hib (Vacuna conjugada Hib)
- PCV 15 PCV13 Y PPSV23 (Vacunas antineumocócicas)
- Polio (IPV)
- Vacunas contra la influenza (Virus atenuado LAIV o la IIV).
- MMR
- Varicela (VAR)
- Vacunas Antimeningocócicas - MenACWY-D [Menactra], MenACWY-CRM (Menveo) MenB (Meningeococos serogrupo B Men B -4C [Bexserol] y Men B- FHbp [Trumenba]
- Tdap
- Virus Papiloma Humano (VPH)
- Dengvaxia (Indicated for the prevention of dengue disease caused by dengue virus serotypes 1, 2, 3 and 4. is approved for use in individuals 9 through 16 years of age with laboratory-confirmed previous dengue infection and living in endemic areas.

COVID 19

2. Vaccines for adults from 21 years of age

Haemophilus influenzae type b vaccine - **Hib**
Hepatitis A vaccine - **HepA**
Hepatitis A and hepatitis B vaccine - **HepA-HepB**
Hepatitis B vaccine - **HepB**
Human papillomavirus vaccine - **HPV**
Influenza vaccine (inactivated) - **IIV4**
Influenza vaccine (live, attenuated) - **LAIV4**

Influenza vaccine (recombinant) - **RIV4**
Measles, mumps, and rubella vaccine - **MMR**
Meningococcal serogroups A, C, W, Y vaccine
MenACWY-D
MenACWY-CRM
MenACWY-TT
Meningococcal serogroup B vaccine
MenB-4C
MenB-FHbp
Pneumococcal 15-valent conjugate vaccine - **PCV15**
Pneumococcal 20-valent conjugate vaccine - **PCV20**
Pneumococcal 23-valent polysaccharide vaccine - **PPSV23**
Tetanus and diphtheria toxoids - **Td**
Tetanus and diphtheria toxoids and acellular pertussis vaccine - **Tdap**
Varicella vaccine - **VAR**
Zoster vaccine, recombinant - **RZV**

3. **Post-transplanted bone marrow patients of <u>any age</u> will be covered for all required vaccinations.**

4. **COVID 19 Vaccine** - not included in the Medicaid Wrap Around but are provided by the Department of Health (DOH).

CHAPTER 6:
What you pay for your Part D prescription drugs

What you pay for your prescription drugs?

You will pay **$0** for all Medicare Part D covered prescription drugs for the entire calendar year.

CHAPTER 7:
Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, 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 or drugs 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. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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 this 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 or urgently needed medical care from a provider who is not in our plan's network**

   You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

   - If you 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 for the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

   - You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. We do not allow providers to bill you for

covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

- 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. You should ask us to pay you back for 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 or drugs 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.

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *Drug Guide* (*Formulary*); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 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. **You must submit your Part D (prescription drug) claim to us within 36 months** of the date you received the 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 195560
San Juan, PR 00919-5560

Requests for payment for Part D drugs:
Humana
P.O. Box 195560
San Juan, PR 00919-5560

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 or drug 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 or drug is covered and you followed all the rules, we will pay for our share of the cost for the service or drug. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you have not paid for the service or drug yet, we will mail the payment directly to the provider.

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, 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 9 of this document.

CHAPTER 8:
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 healthcare 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 1-866-773-5959, 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.

Sección 1.1 Debemos proveer la información de una manera que a usted le resulte útil y en conformidad con su sensibilidad cultural (en idiomas que no sean inglés, en Braille, en texto con letras grandes u otros formatos alternativos, etc.)

Su plan tiene la obligación de garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y sean asequibles para todos los inscritos, incluidos aquellos con poco dominio del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. Algunos ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traductor, los servicios de intérprete, los teleescritores o la conexión TTY (teléfono de texto o teléfono de teleescritores).

Nuestro plan cuenta con servicios gratuitos de intérpretes para responder las preguntas de los afiliados que no hablan inglés. También podemos darle información en Braille, en letra grande o en otros formatos alternos sin

costo, en caso de ser necesario. Se nos exige darle información sobre los beneficios del plan en un formato que le resulte asequible y apropiado. Para que le brindemos información de un modo adecuado para usted, llame a Servicio al Cliente.

Nuestro plan está obligado a brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para los servicios de cuidados médicos preventivos y de rutina para la mujer.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan encontrar proveedores especializados fuera de la red que le proporcionarán la atención necesaria. En este caso, solo pagará los costos compartidos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre a dónde acudir 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 le resulte asequible y apropiado, llame para presentar una queja formal ante el Departamento de Quejas Formales y Apelaciones de Humana al 1-866-773-5959, TTY 711. También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles 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 and drugs

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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. A right to be treated with respect and recognition of their **dignity** and their right to privacy.

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Care.

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 programs and procedures

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 healthcare 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 Plus SNP-DE H4007-026 (HMO D-SNP), 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 and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies 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. Chapters 5 and 6 provide information about Part D prescription drug coverage.

- 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 healthcare 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 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 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 healthcare

You have the right to get full information from your doctors and other healthcare 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 healthcare. 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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, 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 healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives.** There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for healthcare** 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 1-866-773-5959 (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 9 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.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other healthcare providers that you are enrolled in our plan.** Show your plan membership card and your Administración de Seguros de Salud (ASES) (Medicaid) card whenever you get your medical care or Part D prescription drugs.
- **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 premiums to remain a member of our plan.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **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).
- A right to make recommendations regarding the organization’s member rights and responsibilities policy.

CHAPTER 9:
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 the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some 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.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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 integrated organization determination or coverage determination or at-risk 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).

You can get help and information from Administración de Seguros de Salud (ASES) (Medicaid)

You will find contact information for Administración de Seguros de Salud (ASES) (Medicaid) in Exhibit A at the end of this booklet.

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from Administración de Seguros de Salud (ASES) (Medicaid). Information in this chapter applies to **all** of your Medicare and Medicaid benefits. This is sometimes called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, Step-by-step: How a Level 2 appeal is done.

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid.**

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 they are covered, and problems related to payment for medical care.	
Yes. Go on to the next section of this chapter, **Section 5, A guide to the basics of coverage decisions and appeals.**	**No.** Skip ahead to **Section 11** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your 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 benefit is received, and you are not satisfied, 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 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 7 of this chapter.

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

Section 5.2 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 or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please 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)
  - For medical care, your doctor or other health care provider 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.
  - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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 other 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 before 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.** 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 5.3 Which section of this chapter gives the details for your situation?

There are four different 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 6** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 7** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
- **Section 8** 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 9** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* 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, call Customer Care. You can also get help or information from government organizations such as your SHIP.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 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 our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**

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 6.3.**

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 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 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 calendar 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 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 calendar 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 11 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 calendar 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 11 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 make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.3 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 calendar days or 7 calendar 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 7.4 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. Chapter 2 has contact information.**
- **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 65 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 free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a 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.

- If you ask for more time, or if we need 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 take extra days, we will tell you in writing. We can't take extra time 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 6.4 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 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 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. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 11 of this chapter for information on complaints.)

  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 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 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 plan says no to part or all of your appeal, you have additional appeal rights.**

- If we say no to part or all of what you asked for, we will send you a letter.

  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.

  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 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 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.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 136 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

<u>Step 1:</u> 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 free copy of your case file**.
- 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.

- 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.
- 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 about its decision in writing and explain the reasons for it.

- **If the independent 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 independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date the plan receives the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **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 you are requesting meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: You can ask for a Fair Hearing with the state.

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

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision or turning down your appeal.)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5 What if you are asking us to pay you back for our share of a bill you have received for medical care?

We can't reimburse you directly for a Medicaid service or item. If you get a bill that is more than your copay for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself**. We will contact the provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking to be paid back for something you have already paid for:

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill that is more than your copay for *Medicaid* covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the health care provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. 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 Medicare medical care is covered, we will send you the payment for our share of the cost within 60 calendar days after we receive your request.
  - If the Medicaid care that you paid a healthcare provider for is covered and you think we should pay the healthcare provider instead, we will send your healthcare provider the payment for our share of the cost of within 60 calendar days after we receive your request.
  - Then you will need to contact your healthcare provider to get them to pay you back. If you haven't paid for the services, we will send the payment directly to the healthcare 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 6.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 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 healthcare provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D* drug every time. We also use the term Drug Guide instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not in the plan's *Prescription Drug Guide* (*Formulary*). **Ask for an exception. Section 7.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not in the Drug Guide is sometimes called asking for a **formulary exception.**
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.**
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not in our "Drug Guide."**
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs in our *Prescription "Drug Guide."*

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug Guide includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received.* (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber'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 or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.

- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a 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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our website. Chapter 2 has contact information. To submit a coverage determination request online, please go to: **Humana.com/member/member-rights/pharmacy-authorizations**. Fill out the Coverage Determination Request Form. You'll need to send us supporting documentation from the prescribing doctor to show medical need. Your information will be sent to us securely. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which drug is being requested.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **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. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **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. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **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. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request.** Chapter 2 has contact information.

- **For fast appeals, either submit your appeal in writing or call us at (1-866-773-5959)**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website **Humana.com/member/member-rights/pharmacy-authorizations**. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 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 in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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 about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

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.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must 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 a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.

- **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 and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar days** after we receive your request.
- **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. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 Step-by-step: How to make a Level 2 appeal

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 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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- 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.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

- ***For fast appeals:***
  - **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.
- ***For standard appeals:***
  - **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called upholding the decision or 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 drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: 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 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 10** of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 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 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 is 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 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two calendar 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 from someone at the hospital (for example, a caseworker or nurse), 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 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 the 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 will be asked to 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 calendar days before your discharge date, 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 8.2 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 healthcare 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 an immediate 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 Chapter 2.

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 may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
- **If you do *not* meet this deadline**, contact us. If 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.

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.

- 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 also get a written notice from us 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 8.3 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 their 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: Contact the Quality Improvement Organization again and ask for another review.

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the 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.
- 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.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is only about three services: 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 9.2 We will tell you in advance when your coverage will be ending

Legal Term
Notice of Medicare Non-Coverage. It tells you 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 calendar days before our plan is going to stop covering your care. The 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 written 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's decision to stop care.

Section 9.3 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 help 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 Chapter 2.)

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, you may still have appeal rights. Contact the Quality Improvement Organization.

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 information that our plan has given to them.
- By the end of the day the reviewers told 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 9.4 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 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 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could 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 calendar 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 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make 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	**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.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. 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	**An Administrative Law Judge or attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- 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.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. 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	• Did someone not respect your right to privacy or share confidential information?
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, pharmacists, 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 or exam room, or getting a prescription.
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?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for 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 or drugs 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 11.2 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 11.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Grievance Filing Instructions**

  File a verbal grievance by calling Customer Care at 1-866-773-5959 (TTY: 711).

  Send a written grievance to:
  Humana Grievances and Appeals Dept.
  P.O. Box 195560
  San Juan, PR 00919-5560

  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.** You can make the complaint at any time after 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 within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If 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 11.4 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 directly 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 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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.

You can also submit a complaint about Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) directly to your state Medicaid agency. To submit a complaint contact information for Administración de Seguros de Salud (ASES) (Medicaid) can be found in Exhibit A in the back of this document.

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs 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 may be able to end your membership because you have Medicare and Medicaid

- Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:
  - Original Medicare *with* a separate Medicare prescription drug plan,
  - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

  Contact Administración de Seguros de Salud (ASES) (Medicaid) to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).
- Other Medicare health plan options are available during the **Annual Enrollment Period.** Section 2.2 tells you more about the Annual Enrollment Period.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the Annual Open Enrollment Period). During this time, review your health and drug 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

    OR

  - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 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 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the annual 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 choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **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. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your 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 Administración de Seguros de Salud (ASES) (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.

  Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

  Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid".

Section 2.5 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 2025*** 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. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan. – If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. – If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. • 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 Plus SNP-DE H4007-026 (HMO D-SNP) when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Administración de Seguros de Salud (ASES) (Medicaid) benefits, contact Administración de Seguros de Salud (ASES) (Medicaid). Contact information for Administración de Seguros de Salud (ASES) (Medicaid) can be found in "Exhibit A" in the back of this document. Ask how joining another plan or returning to Original Medicare affects how you get your Administración de Seguros de Salud (ASES) (Medicaid) coverage.

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

Until your membership in Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) ends, and your new Medicare and Medicaid coverage begins, you must continue to get your medical services, items and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) must end your membership in the plan in certain situations

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

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) 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 are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. If you are no longer eligible for the plan, your membership will end after a six month grace period. You will receive a letter explaining that we must disenroll you from our plan if you do not regain your eligibility for Administración de Seguros de Salud (ASES) (Medicaid) assistance within the grace period.
- If you do not pay your medical spenddown, if applicable
- 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 lie or withhold information about other insurance you have that provides prescription drug coverage
- 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.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

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.

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

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

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 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 11:
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 Plus SNP-DE H4007-026 (HMO D-SNP), 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 9.

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 (including, but not limited to, the government of Puerto Rico compulsory automobile insurance, known as ACAA) 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 9 *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* in this *Evidence of Coverage*.

CHAPTER 12:
Definitions of important words

Chapter 12. 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 healthcare 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.

Appeal - An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs 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 more than the plan's allowed cost sharing amount. As a member of Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP), you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period - The way that Original Medicare measures your use of 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.(See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See **"Interchangeable Biosimilar"**).

Brand Name Drug - A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage - The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent **$2,000** for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs.

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 or prescription drugs.

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, provider or pharmacy for covered services or prescription drugs.

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 or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage Determination - A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs - The term we use to mean all of the prescription drugs covered by our plan.

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.

Daily cost sharing rate - A daily cost sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost sharing rate" is $1 per day.

Deductible - The amount you must pay for health care or prescriptions before our 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.

Dispensing Fee - A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) - A type of plan that enrolls individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the individual's eligibility.

Dually Eligible Individuals - A person who is eligible for Medicare and Medicaid coverage.

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.

Exception - A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary - A document that lists all prescription drugs covered by a plan.

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).

Generic Drug - A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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, Medical Benefits Chart 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 full time 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 Coverage Stage - This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are also known as full-benefit dually eligible individuals.

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

Integrated 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.

List of Covered Drugs (Formulary or Drug Guide) - A list of prescription drugs covered by the plan.

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.

Mail-Order Pharmacy - A pharmacy that fills and sends prescriptions through the mail to the member's home.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

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 any late enrollment penalty, Medicare Part A and Part B premiums, and prescription drugs do not count toward the 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 Accepted Indication - A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary - Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare - The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period - The time period from January 1 to 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 i) an HMO, ii) a PPO, a iii) a Private Fee-for-Service (PFFS) plan, or iv) a 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 Pharmacy." and "Network Provider."

Network Pharmacy - A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider - Provider is the general term 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.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 Plus SNP-DE H4007-026 (HMO D-SNP).

Out-of-Network Pharmacy - A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility - A provider or facility that 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 or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C - see Medicare Advantage (MA) Plan.

Part D - The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs - Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose "Extra Help", you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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.

Prescription Drug Guide (Formulary) - A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

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 or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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 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.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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 and drug plans or return to Original Medicare due to certain events or changes in their life. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you. This is also referred to as a Special Election Period or "SEP."

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.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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 –A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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.

PUERTO RICO	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) PO Box 191179 San Juan, PR 00919-1179 1-877-725-4300 (toll free) 1-787-721-6121 (local) 1-878-919-7291 (local TDD) https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx
Quality Improvement Organization	Livanta BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 1-866-815-5440 1-866-868-2289 (TTY) 1-855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Administración de Seguros de Salud (ASES) (Medicaid) PO Box 70184 San Juan, PR 00936-8184 1-787-641-4224 (Local and Toll Free) 1-787-625-6955 (TTY) 1-787-763-5250 (fax) https://www.medicaid.pr.gov
AIDS Drug Assistance Program	Puerto Rico AIDS Drug, Copays and Coinsurance Assistance Program Departamento de Salud OCASET Programa Ryan White Parte B P.O Box 70184 San Juan, PR 00936-8184 1-787-765-2929 Ext. 5106-5137 https://www.salud.pr.gov/CMS/137

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services.
Humana Inc.:

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

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **866-773-5959 (TTY: 711)**. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **866-773-5959 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

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

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.
GHHNDN2025PR

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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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、1-866-773-5959 (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

Notes

Notes

Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP) Customer Care

Method	Customer Care – Contact Information
CALL	1-866-773-5959 Calls to this number are free. You can call us 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 and Saturday 7 a.m. to 6 p.m. from Apr. 1 – Sept. 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	1-800-658-9928
WRITE	Humana P.O. Box 195560 San Juan, PR 00919-5560
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.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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

Important Plan Information

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