2026

Member Handbook

Humana Dual Integrated (HMO D-SNP)

Michigan

Humana®

Humana Dual Integrated (HMO D-SNP) Member Handbook

January 1, 2026–December 31, 2026

Your Medicare and Medicaid Health Benefits, Services and Prescription Drug Coverage as a Member of Humana Dual Integrated (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through December 31, 2026. It explains health care services, behavioral health services, prescription drug coverage, and long-term services and supports. Long-term services and supports include long-term care and home and community based waivers (HCBS). HCBS waivers can offer services that will help you stay in your home and community. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

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

This Humana Dual Integrated (HMO D-SNP) plan is offered by Humana Health Plan, Inc.
When this *Member Handbook* says "we," "us," or "our," it means Humana Health Plan, Inc. When it says "the plan" or "our plan," it means Humana Dual Integrated (HMO D-SNP). This document is available for free in Spanish. You can make a standing request to get materials, now and in the future, in a language other than English or in an alternate format.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-281-6070 (TTY: 711). Estamos disponibles de lunes a viernes, de 8 a.m. a 8 p.m. hora. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

- Call Member Services if you want to make or change a standing request at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.
- We will keep your preferred language other than English and/or alternate format for future mailings and communications.
- You will not need to make a separate request each time.

OMB Approval 0938-1444 (Expires: June 30, 2026)

Disclaimers

Humana Dual Integrated (HMO D-SNP) H0963-001 is a Dual Eligible Special Needs HMO SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in this Humana plan depends on contract renewal.

Coverage under Humana Dual Integrated (HMO D-SNP) is qualifying health coverage called "minimum essential coverage". It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Limitations, copays, and restrictions may apply. For more information, call Humana Dual Integrated (HMO D-SNP) Member Services or read this Humana Dual Integrated (HMO D-SNP) Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Humana Dual Integrated (HMO D-SNP) pay for your services.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027. 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.

Chapter 1: Getting started as a member

Introduction

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

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If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 855-281-6070, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. The call is free. **For more information**, visit **Humana.com**.

A. Welcome to our plan

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Humana Dual Integrated (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 Dual Integrated (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 Dual Integrated (HMO D-SNP) is designed for people who have Medicare and Michigan Medicaid. Because you have Michigan Medicaid, you may receive assistance with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Michigan Medicaid may also provide other benefits to you by covering health care services and prescription drugs that are not usually covered under Medicare. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Humana Dual Integrated (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Humana Dual Integrated (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 Michigan Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care overage, including your prescription drug coverage.

B. Information about Medicare and Michigan Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Michigan Medicaid

Michigan Medicaid is the name of Michigan's Medicaid program. Michigan Medicaid is run by the state and is paid for by the state and the federal government. Michigan Medicaid helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Michigan approved our plan. You can get Medicare and Michigan Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Michigan allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Michigan Medicaid services isn't affected.

C. Advantages of this plan

You'll now get all your covered Medicare and Michigan Medicaid services from Humana Dual Integrated (HMO D-SNP), including prescription drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You will have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You will have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you’re taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Humana Dual Integrated (HMO D-SNP) H0963-001: In most instances you’ll be enrolled in Humana Dual Integrated (HMO D-SNP) H0963-001 for your Medicare benefits the 1st day of the month after you request to be enrolled in Humana Dual Integrated (HMO D-SNP) H0963-001. You may still receive your Michigan Medicaid from your previous Michigan Medicaid health plan for one additional month. After that, you’ll receive your Michigan Medicaid services through Humana Dual Integrated (HMO D-SNP) H0963-001. There will be no gap in your Michigan Medicaid coverage. Please call us at the number at the bottom of the page if you have any questions.

D. Our plan's service area

Our service area includes the following county/counties in Michigan: Macomb and Wayne.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Michigan Medicaid, **and**
- are age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program.
- are receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount).

If you lose your Michigan Medicaid eligibility but can be expected to regain it within 6 months, we'll continue to provide all Medicare benefits covered by Humana Dual Integrated (HMO D-SNP). When your Michigan Medicaid coverage ends, we won't pay for your Michigan Medicaid benefits. You will have to pay for any services that you continue to receive that are usually covered by Michigan Medicaid while you're still enrolled with us for your Medicare coverage. You will still get your Humana Dual Integrated (HMO D-SNP) Medicare benefits at no cost, but you may have to pay Medicare Part A and/or Part B premiums, and Part D prescription drug premiums. Please call Member Services at the number at the bottom of this page for additional information.

We'll assist you to regain your Michigan Medicaid eligibility. If your Michigan Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage:

- We'll resume paying for your Michigan Medicaid benefits.
- Your enrollment with our plan will continue.
- We will cover Medicare cost-sharing for services you received while you were waiting for your Michigan Medicaid coverage to restart.
- We will pay for any Michigan Medicaid services you received while you were waiting for your Michigan Medicaid coverage to restart. We will not pay for any Home and Community Based Services (HCBS) you received during the time your Medicaid eligibility was not active.



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 855-281-6070, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. The call is free. **For more information**, visit **Humana.com**.

If you can't regain Michigan Medicaid within 6 months, we'll disenroll you from Humana Dual Integrated (HMO D-SNP). If you regain Michigan Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Please call Member Services at the number at the bottom of this page for additional information.

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

When you first join our plan, you get a health risk assessment (HRA) within in 90 days before or after your enrollment effective date. We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

Humana Dual Integrated (HMO D-SNP) must maintain your current providers and services you're receiving at the time of Enrollment. This includes drugs and providers which aren't part of our network. How long you'll continue to receive these services depends on what services you're receiving and why you're getting them. Only after we've completed your HRA will we consider any changes to the services you're getting at the time you enroll.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, LTSS, health related social needs, and functional needs. The care plan will focus on your goals taking into account your concerns, wants, needs and strengths. It'll include a summary of your health status and your plan for addressing your concerns. You'll be asked to sign your care plan after it's satisfactory to you.

Your care plan includes:

- your health care goals,
- a timeline for getting the services you need,

- your cultural values and the communication needs and preferences,
- your preferences for care, services, and supports,
- your prioritized list of concerns, goals and objectives, and strengths,
- specific providers, supports and services including amount, scope, and duration,
- a summary of your health status,
- the plan for addressing your concerns or goals and measures for achieving them,
- the person(s) responsible for helping you achieve your goals,
- due dates for the interventions and Reassessment, and
- a plan to address health related social needs such as food or housing security.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Summary of important costs

Your costs may include the following:

- Our plan has no premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Medicare Prescription Payment Plan Amount (**Section H3**)

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and the AIDS Drug Assistance Program (ADAP). Learn more about this program in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already* get help from one of these programs, **the information about premiums in this *Member Handbook* does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services at the number at the bottom of this page and ask for the "LIS Rider".

H1. Our plan has no premium

You do not pay a separate monthly plan premium for Humana Dual Integrated (HMO D-SNP).

H2. 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 E** above to be eligible for our plan, you must maintain your eligibility for Michigan Medicaid as well as have both Medicare Part A and Medicare Part B. For most Humana Dual Integrated *members*, Michigan Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

H3. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 Section I3 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

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

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* at **Humana.com/plandocuments** or download it from this website.

The contract is in effect for the months you are enrolled in our plan between January 1, 2026 and December 31, 2026.

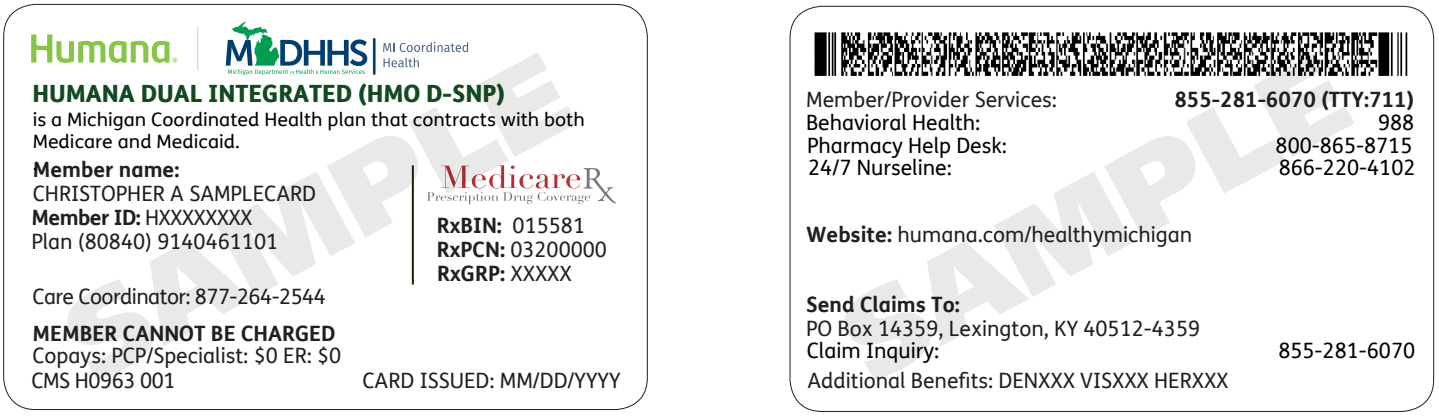
J. Other important information you get from us

Other important information we provide to you includes your Member ID card, a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*, also known as a *Drug List* or *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Michigan Medicaid services, including LTSS, certain behavioral health services, certain behavioral health services, and prescriptions. You show this card when you

get any services or prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you are a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at **Humana.com/plandocuments**.

The *Provider and Pharmacy Directory* lists health care professionals, facilities, and support providers that you may use as a Humana Dual Integrated (HMO D-SNP) member. We also list the pharmacies that you may use to get your prescription drugs. During the first 90 days after you enroll with Humana Dual Integrated (HMO D-SNP), you can see any provider you've seen within the previous twelve (12) months, even if the provider isn't in our network.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**

- LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Durable Medical Equipment (DME)

We included our List of DME with this *Member Handbook*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of this *Member Handbook* to learn more about DME equipment.

J3. List of Covered Drugs

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section B**. Medicare approved the Humana Dual Integrated (HMO D-SNP) *Drug List*.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Member Handbook* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call your Care Coordinator or Member Services or visit our website at the address at the bottom of the page. The *Drug List* will include a section that lists all Medicaid drugs covered in our plan. This information will also be found at our website or by calling your Care Coordinator or Member Services.

J4. The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we have paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take, such as increases in price and other drugs with

lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your enrollee profile up to date

You can keep your enrollee profile up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your enrollee profile to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in who your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your enrollee profile may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Member Services

CALL	855-281-6070 This call is free. We're available Monday – Friday, from 8 a.m. – 8 p.m.. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Hours of operation are the same as above.
WRITE	Humana P.O. Box 14359 Lexington, KY 40512-4169
WEBSITE	**Humana.com** Live chat available through **Humana.com**

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services, **or**
        - the amount we will pay for your health services.
    - Call us if you have questions about a coverage decision about health care.
    - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook.*
- appeals about your health care
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
    - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Member Services.
- complaints about your health care



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 855-281-6070, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. The call is free. **For more information**, visit **Humana.com**.

- You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F** below).
- You can call us and explain your complaint at 855-281-6070.
- If your complaint is about a coverage decision about your health care, you can make an appeal. *(Refer to the section above).*
- You can send a complaint about our plan right to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can contact the MI Community, Home, and Health Ombudsman (MI CHHO) to help you with your complaint. The MI Community, Home, and Health Ombudsman (MI CHHO) can be reached at 1-800-746-6456 or www.meji.org/contact-meji.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs, **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9, Section F4**, of this *Member Handbook*.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- complaints about your drugs
  - You can make any complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above, **Chapter 2, Section A).**
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- payment for health care or drugs you already paid for

- For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
- If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Member Handbook*.

B. Your care coordinator

With Humana Dual Integrated (HMO D-SNP), you have a whole care team to work with to help support meeting your health needs and goals. This service is part of this plan and there is no cost to you.

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

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

Our care coordinators are here to help keep you safe and healthy. For example, your care coordinator may:

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

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

CALL	855-281-6070 This call is free. We're available Monday – Friday, from 8 a.m. – 8 p.m.. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. The call is free. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Hours of operation are the same as above.
WRITE	Humana PO Box 14359 Lexington, KY 40512-4169
WEBSITE	**Humana.com** Live chat available through **Humana.com**

Contact your care coordinator to get help with:

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

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

- Adult Day Service - Also known as Adult Day Care
- Behavioral Services
- Day Habilitation – Also known as Habilitation
- Emergency Home Response System
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Home Health Care

- Homemaker
- Nursing - Intermittent
- Nursing - Skilled
- Personal Assistant
- Personal Emergency Response System
- Physical, Occupational and Speech Therapy – also known as Rehabilitation Services
- Prevocational Services
- Respite
- Skilled nursing care
- Specialized Equipment and Supplies, and
- Supportive Living Program – Also known as Supportive Living Service

C. MI Options State Health Insurance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Michigan, the SHIP is called MI Options.

MI Options is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	800-803-7174 Monday – Friday 8 a.m. – 8 p.m. The call is free.
TTY	711 Monday – Friday 8 a.m. – 8 p.m. The call is free.
WRITE	MI Options P.O. Box 30676 Lansing, MI 48909
EMAIL	MDHHS-MIOPTIONS@Michigan.gov
WEBSITE	www.michigan.gov/MDHHSMIOptions

Contact MI Options SHIP for help with:

- questions about your Medicare
- MI Options SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,

- understand your plan choices,
- answer questions about switching plans,
- make complaints about your health care or treatment, **and**
- straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health for quality improvement. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

CALL	1-888-524-9900 This call is free.
TTY	The QIO uses a direct TTY number. The TTY phone number is 1-888-985-8775. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Commence Health 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	**www.livantaqio.com**

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care, such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, ***or***
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

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

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

contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24-hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at **www.Medicare.gov/talk-to-someone**
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	**www.medicare.gov** • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly "wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. • To submit a complaint to Medicare, go to **www.medicare.gov/my/medicare-complaint**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

F. Michigan Medicaid

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

You're enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Beneficiary Help Line: 1-800-642-3195 or go to www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support.

CALL	Beneficiary Help Line 1-800-642-3195 8:00 am – 7:00 pm Monday through Friday (except holidays)
TTY	1-866-324-5553 Monday – Friday 8 a.m. – 5 p.m. The call is free.
WRITE	400 S. Pine St. 5th Floor Lansing, MI 48933
EMAIL	beneficiarysupport@michigan.gov
WEBSITE	**www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support**

G. MI Community, Home, and Health Ombudsman (MI CHHO)

The MI Community, Home, and Health Ombudsman (MI CHHO) works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MI Community, Home, and Health Ombudsman (MI CHHO) also helps you with service or billing problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-746-6456
TTY	1-877-204-1012 Monday – Friday 8 a.m. – 4:30 p.m. The call is free.
WRITE	15851 S. US 27, Suite 73 Lansing, MI 48906
EMAIL	MI-CHHO@meji.org
WEBSITE	**https://meji.org/mhlo**

H. Michigan Long Term Care Ombudsman Program (MLTCOP)

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

The Michigan Long Term Care Ombudsman Program (MLTCOP) isn't connected with our plan or any insurance company or health plan.

CALL	517-827-8040.

WRITE	MLTCOP - MEJI 15851 S. US 27, Suite 73 Lansing. MI 48906
EMAIL	MLTCOP@meji.org
WEBSITE	**www.mltcop.org/**

I. Programs to Help People Pay for Drugs

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

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	**www.medicare.gov**

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- If you already have a document that proves you have qualified for "Extra Help," you can show it the next time you go to a pharmacy to have a prescription filled. You can provide evidence to us, or show proof at the pharmacy.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

J. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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 their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	**www.ssa.gov**

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	**www.rrb.gov**

L. Other resources

Quality Improvement (QI) Program

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

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

Introduction

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

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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as and your cost-sharing amount as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay only your share of the cost for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Michigan Medicaid. This includes behavioral health and LTSS.

Our plan will generally pay for the health care services, covered behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
    - In most cases, your network PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
    - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter)**.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
    - We cover emergency or urgently needed care from an out-of-network provider (for more

information, go to **Section I** in this chapter).

- If you need care that our plan covers and our network providers can't give it to you, you can get the care from an out-of-network provider. You must obtain authorization from the plan prior to seeking care from an out-of-network provider. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- The plan covers a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to you.

C. Your care coordinator

C1. What a care coordinator is

Your Care Coordinator will help establish priorities and to link all of your doctors, pharmacies, behavioral health care and long-term care supports and services through your health plan. The Care Coordinator will help make sure that your doctors and other providers work together to meet your needs and honor your choices. The Care Coordinator connects you to supports and services that you need to be healthy and to live where you wish. This person will assist with your care plan, answer your questions, help get appointments and services, arrange transportation, and more.

With your Humana Dual Integrated (HMO D-SNP), you have a whole care team to work with to help support meeting your health needs and goals. This service is part of your plan and there is no cost to you.

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

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

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

Our care coordinators are here to help keep you safe and healthy. For example, your care coordinator may:

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

C2. How you can contact your care coordinator

You can contact your care coordinator by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. This call is free.

C3. How you can change your care coordinator

You can request to change your care coordinator at any time by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. This call is free.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of "PCP," and what a PCP does for you

Your Primary Care Provider (PCP)

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

In some cases, a specialist may be a PCP, call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m.– 8 p.m.. The call is free. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's *Drug List*. There you can also use the physician finder, get

health news and information.

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

- Family doctor
- General practitioner
- Internist
- Federally Qualified Health Center or a Rural Health Center
- Women's Health Care Provider (WHCP) or OB/GYN - A Women's Health Care Provider (WHCP) is a doctor, nurse practitioner or other provider who specializes in obstetrics, gynecology, or family practice. Female members may choose a WHCP as their PCP or may use a WHCP as needed and without a referral.

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

Your choice of PCP

For information on choosing your PCP, call Member Services at 855-281-6070 (TTY: 711).We're available Monday – Friday, from 8 a.m.– 8 p.m.. The call is free. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's *Drug List*. There you can also use the physician finder and get health news and information.

If you would prefer to have a PCP that has the same cultural, ethnic or racial background as you, please call Member Services. Members who identify as American Indian/Alaskan Native may use providers who are designated as Indian Health Care Providers if they choose to. You are not limited to these providers and can choose any network provider. For help in locating an Indian Health Care provider, please call Member Services at the number listed above.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

If you want to change your PCP for any reason, you must call Member Services to let us know. Change requests received by the last day of the month will usually be effective on the first day of the following month. We will send you a new Member ID Card with your new PCP on it. Member Services can also help you schedule your first appointment, if needed.

To find the PCPs you can choose from:

- Look in our *Provider and Pharmacy Directory*.
- Look on our website at **Humana.com/findadoctor.**
- Call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.

The call is free.

If you need a copy of the *Provider and Pharmacy Directory*, call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's *Drug List*. There you can also use the physician finder and get health news and information.

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

Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. You can call us if you need help choosing a different PCP. Be sure to tell Member Services 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.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots, COVID-19 vaccinations, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- All covered preventive services as long as you get them from a network provider.
- Outpatient mental health and substance abuse medication management, assessments, consultation and therapy with in network providers.
- Emergency or crisis treatment for mental health and substance abuse problems.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

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

Your PCP or Women's Health Care Provider (WHCP) can recommend a specialist to you if you have a specific problem. Your PCP or WHCP can also recommend a lab or hospital to you for special services.

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

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

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll 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'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization may be applicable.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new

provider to manage your care.

- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

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

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

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Michigan Medicaid.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

Long-Term Supports and Services (LTSS) are services that help elderly people and people with disabilities meet their daily needs for help and improve the quality of their lives. Examples of LTSS include help with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, usually in homes and communities, but also in nursing homes and other facilities.

F. Behavioral health (mental health and substance use disorder) services

All Medicaid and Medicare behavioral health services are covered by your plan. All existing Medicare and Medicaid behavioral health services will continue to be provided for people currently receiving care and who enroll in MICH. Certain behavioral health services covered by Medicaid are managed by Michigan Pre-paid Inpatient Health Plans (PIHPs), organizations that the Michigan Department of Health and Human Services contracts with to administer Medicaid covered behavioral health benefits. All Medicaid covered Behavioral Health services not managed by the PIHPs and all behavioral health services covered by Medicare will be managed by us. If you have questions about behavioral health, contact your Care Coordinator.

G. How to get self-directed care

G1. What self-directed care is

You have the option to self-direct your services if you qualify. You would control a budget and have the right to hire and manage personal care workers and other providers.

G2. Who can get self-directed care (for example, if it's limited to waiver populations)

Your care coordinator will work with you to determine whether you qualify for self-directed services.

G3. How to get help in employing personal care providers (if applicable)

Talk to your care coordinator if you think you need services that can be self-directed.

H. Transportation services

- **If you have a medical emergency, dial 911**
- Call 911 if you need emergency transportation. You don't need prior approval in an emergency.
- Non-emergency ground ambulance services aren't covered by this plan. **Other transportation services are covered.**
- We may be able to help you get to your medical appointments and, if you qualify, may be able to help with transportation for other things. If you need help with transportation, talk to your care coordinator.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

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

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- in the case of a pregnant woman in active labor, when:
    - There isn't enough time to safely transfer you to another hospital before delivery.
    - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S and it's territories or worldwide, from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay in telling us. Call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

Covered services in a medical emergency

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. 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** 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. Transportation back to the United States from another country is NOT covered. Pre-scheduled, pre-planned treatments (including treatment for an ongoing condition) and/or elective procedures are NOT covered.

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. To learn more, refer to the Benefits Chart in **Chapter 4, Section D** of this *Member Handbook*.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

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

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider, **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

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

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

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

If it isn't possible or reasonable to get to a network provider, given your time, place, or circumstances, we cover urgently needed care you get from an out-of-network provider.

If you have a mental health crisis, you can get help by calling the free Crisis Hotline at 844-462-7474 (Wayne County) or 586-307-9100 (Macomb County) (TTY 711). Qualified mental health professionals will be available 24 hours per day, 7 days per week to answer your questions, assess your mental health, and provide and coordinate services as needed.

If you think you need urgent care, you can:

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

   OR

2. Call our 24-hour nurse advice line at 866-220-4102 (TTY: 711) 24-hours a day, 7 days a week.

   OR

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

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

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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. 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** 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. Transportation back to the United States from another country is NOT covered. Pre-scheduled, pre-planned treatments (including treatment for an ongoing condition) and/or elective procedures are NOT covered.

I3. Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website for information on how to obtain needed care during a declared disaster: **Humana.com/alert**.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

J. What if you're billed directly for covered services

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill. If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

J1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4, section D** of this *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

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

Chapter 9 Section E of this *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

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

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

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

If you want to participate in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you'll take part in a clinical trial.

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

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study

- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

Medicare Inpatient Hospital coverage limits apply (please refer to the Medical Benefits Chart in **Chapter 4, Section C** of this *Member Handbook*).

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

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

M2. DME ownership when you switch to Original Medicare

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

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

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or a an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

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

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

If oxygen equipment is medically necessary **after you rent it for 36 months,** your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months.
- oxygen equipment and supplies for up to 5 years if medically necessary.

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

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

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

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Your covered services

This chapter tells you about services our plan covers and how much you pay for each service. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

Because you get help from Michigan Medicaid, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

B. Rules against providers charging you for services

We don't allow our providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical

order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met.

You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and Michigan Medicaid covered services according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary". Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facilty. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you **don't** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets approval from us first. This is called *prior authorization* (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (*).

If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

Important Benefit Information for Members with Certain Chronic Conditions

- If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits through the Healthy Options Allowance:
- Members diagnosed with one or more qualifying chronic conditions identified below and have a medical claim with Humana with a date of service on or after 1/1/2021 reflecting such diagnosis may be eligible to receive additional benefits through the Healthy Options Allowance.
    - Autoimmune disorders
    - Cancer
    - Cardiovascular disorders

- Conditions associated with cognitive impairment
- Conditions with functional challenges
- Chronic alcohol use and other substance use disorders
- Chronic and disabling mental health conditions
- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic kidney disease
- Chronic lung disorders
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Chronic hyperlipidemia
- Chronic hypertension
- Neurologic disorders
- Post-organ transplant
- Severe hematologic disorders
- Stroke

- In some cases, members may be able to qualify by taking a Health Risk Assessment (HRA) and indicating a diagnosis of one or more eligible chronic conditions.
- Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.
- Contact us for additional information.

Uniformity Flexibility Non-Emergency Medical Transportation

If you are diagnosed with any of the chronic condition(s) identified below, you are eligible for the Uniformity Flexibility Non-Emergency Medical Transportation benefit.

- Cancer
- Chronic Kidney Disease (CKD)
- End Stage Renal Disease (ESRD)

Please see details in the "Help with certain chronic conditions" section of the Benefits Chart below.

All preventive services are free. You will find this apple shows the preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0 copay
Acupuncture We pay for up to 20 visits per calendar year if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease) • not associated with surgery; **and** • not associated with pregnancy You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Acupuncture (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Your plan also allows services to be received by a provider licensed to perform acupuncture.	$0 copay
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0 copay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 copay *Prior authorization may be required
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0 copay

Covered Service	What you pay
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0 copay
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and older • clinical breast exams once every 24 months	$0 copay
Breast pumps (Medicaid) • Hospital-grade electric breast pump ○ Rental only ○ Covered for a member with a Neonatal Intensive Care Unit (NICU) infant, up to 3 months of age ○ Covered when the infant has a severe feeding problem, or the infant or mother is hospitalized, resulting in a physical separation of the mother and infant ○ Continued coverage beyond the initial 3 months, additional documentation must be provided • Personal use double electric breast pump ○ Purchase only ○ Covered once per 5 years when criteria is met • Manual breast pump ○ Purchase only ○ Once per birth when criteria is met ○ For members who had a multiple birth delivery, only 1 pump is covered	$0 copay

Covered Service	What you pay
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's referral. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 copay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0 copay
Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0 copay
Certified nurse-midwife (CNM) services (Medicaid) Coverage includes but is not limited to: • Maternity care (Obstetrics), including antepartum care, hospital delivery and postpartum care • Newborn care • Primary care services for women throughout their lifespan, including physical exams • Diagnosis and treatment of common health problems • Gynecological and family planning services • Reproductive health services • Contraceptive services • Treatment of male partners for sexually transmitted infection and reproductive health **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Certified nurse-midwife (CNM) services (Medicaid) (continued) • The prescribing of pharmacological and nonpharmacological interventions and treatments that are within the CNM's specialty	$0 copay
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months **Cervical and vaginal cancer screening (Medicaid)** Outpatient services that are routinely provided as part of, or as as follow-up to a family planning visit: • PAP screens and treatment for pre-cancerous conditions which commonly originate from a Sexually Transmitted Infection (STI).	$0 copay
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment **Chiropractic services (Medicaid)** Medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. • Up to 18 chiropractic visits per year; • 1 set of spinal x-rays per year (Subluxation must be demonstrable on x-rays).	$0 copay *Prior authorization may be required

Covered Service	What you pay
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	$0 copay Cost sharing for this service will vary depending on individual services provided under the course of treatment.
Colorectal cancer screening We pay for the following services: • 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 aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • 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. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Colorectal cancer screening (continued) • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	$0 copay
Community Health Worker (CHW) Services CHWs are non-licensed public health providers who facilitate access to needed health and social services for members. CHW services focus on preventing disease, disability, and other chronic conditions or their progression, and promoting physical and mental health. CHW services must be recommended by a licensed provider. Conditions that may define a member's eligibility for CHW services include the following: • diagnosis of one or more chronic health conditions including behavioral health; • suspected or documented unmet health-related social needs; or • pregnancy and post-partum.	$0 copay
Counseling to stop smoking or tobacco use Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Counseling to stop smoking or tobacco use (continued) • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year). **Tobacco cessation counseling (Medicaid)** Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation medication or without medication. • 4 counseling sessions per quit attempt; • 2 quit attempts per 12 month period (8 per year); • No limitations for pregnant women.	$0 copay
Dental services Humana Dual Integrated (HMO D-SNP) will pay for the following services: • examinations and evaluations are covered once every six months • cleaning is a covered benefit once every six months • silver diamine fluoride treatment is covered with a maximum of six applications per lifetime • X-rays • bitewing x-rays are a covered benefit only once in a 12-month period • a panoramic x-ray is a covered benefit once every five years • a full mouth or complete series of x-rays is a covered benefit once every five years • fillings • tooth extractions • covered once every five years • sealants are covered once every three years, if criteria are met **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required **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.

Covered Service	What you pay

Dental services (continued)
• indirect restorations (crowns) are covered once every 5 years per tooth, if criteria are met
• root canal therapy/re-treatment of previous root canal comprehensive periodontal evaluation
• scaling in presence of inflammation
• periodontal scaling and root planning
• other periodontal maintenance
We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. 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 organ transplantation.
In addition, we cover **Mandatory Supplemental Dental Benefits** which include preventive and diagnostic services.
Dental services (Medicaid)
• Oral prophylaxis: 1 every 6 months
  ○ Includes routine scaling and debridement, stain removal and polishing of tooths surface
• Sealants: 1 every 3 years
  ○ Includes repair and replacement of the sealant for 3 years
• Crowns
  ○ Stainless steels crowns: 1 every 2 years
  ○ Crowns are covered once per 5 years on the same tooth
• Root canals: No limit
• Re-treatment of root canals: 1 per tooth per lifetime
• Apicoectomy: Covered after at least one root canal procedure and re-treatment has no be successful or is not possible
• Full mouth debridement: 1 every 365 days
This benefit is continued on the next page.
	$0 copay
	*Prior authorization may be required
	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.

Covered Service	What you pay
Dental services (continued) ○ Cannot be done on the same date of service as a comprehensive periodontal evaluation or prophylaxis • Periodontal maintenance: 1 every 6 months • Complete and partial dentures: 1 every 5 years • Relines or duplications of dentures: Covered after the initial 6 months, once within a 2 year period • Repairs and adjustments: Covered after the initial 6 months, twice in a 12 month period • Oral surgery: Procedures involving the jaw or facial bones are considered a medical benefit • Extractions: No limits • Anesthesia: When medically necessary • Professional visits: A hospital or ambulatory surgical center call is covered when medically necessary	$0 copay *Prior authorization may be required **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.
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment.	$0 copay
Diabetes prevention program services Our plan will pay for Medicare Diabetes Prevention Program services and Michigan Diabetes Prevention Program services: **Medicare Diabetes Prevention Program (MDPP)** • Our plan will pay for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: ○ long-term dietary change, and ○ increased physical activity, and ○ ways to maintain weight loss and a healthy lifestyle. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Diabetes prevention program services (continued) **Michigan Diabetes Prevention Program (MiDPP) services** • Our plan will pay for 28 structured health behavior change one-hour sessions provided by a Medicaid-enrolled Lifestyle Coach associated with an enrolled MiDPP provider for members who are: ○ overweight or obese as defined by Body Mass Index (BMI) and has one of the following: ○ elevated blood glucose levels according to CDC standards for blood glucose level requirements ○ history of gestational diabetes mellitus (GDM) ○ score at "high risk" on the CDC prediabetes risk test ○ a member with previously diagnosed type 1 or type 2 diabetes or who's currently pregnant can't enroll in MiDPP	$0 copay
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0 copay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Diabetic self-management training, services, and supplies (continued) • 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, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	$0 copay *Prior authorization may be required

Covered Service	What you pay
Doula services The plan will pay for different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. The plan will pay for twelve total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. Additional visits may be requested. Doula support during the perinatal period may include, but isn't limited to: • prenatal services • labor and delivery services • postpartum services **A recommendation for doula services must come from a licensed healthcare provider.**	$0 copay
Durable Medical Equipment and related supplies Refer to **Chapter 12** in this *Member Handbook* for a definition of "Durable medical equipment (DME)". We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Durable Medical Equipment and related supplies (continued) • dialysis care equipment Other items may be covered. With this *Member Handbook*, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You can also find the most recent list of brands, makers, and suppliers on our website at **Humana.com**. Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If your'e new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand isappropriate for your medical condition. For more information about appeals, refer to Chapter 9 of this Member Handbook.	$0 copay *Prior authorization may be required
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, ***and*** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life or to that of your unborn child; **or** • serious harm to bodily functions; **or** **This benefit is continued on the next page.**	$0 copay If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

Covered Service	What you pay

Emergency care (continued)
• sloss of a limb, or loss of function of a limb.
• In the case of a pregnant woman in active labor, when:
  ○ There isn't enough time to safely transfer you to another hospital before delivery.
  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.
You are covered for emergency care world-wide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to Humana for reimbursement. 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.
	$0 copay
	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) **This benefit is continued on the next page.**	$0 copay *Prior authorization is required for infertility and genetic testing

Covered Service	What you pay
Family planning services (continued) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	$0 copay *Prior authorization is required for infertility and genetic testing
Gender affirmation services (Medicaid) Gender affirmation/confirming medical, surgical, and pharmacologic treatments and procedures. Services must be medically necessary for the treatment of clinically diagnosed gender dysphoria.	$0 copay
Group prenatal care services The plan will pay for group prenatal care services if you have a low-risk pregnancy that doesn't require individual monitoring. You'll be educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception. Group sessions are facilitated by a trained healthcare provider and include others in similar stages of pregnancy. The plan may cover up to 12 total in-person group sessions per pregnancy in addition to the required individual professional maternity visit, if: • The group session is in addition to but doesn't replace the individual prenatal physical assessment visit. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Group prenatal care services (continued) • The group session is at least 60 minutes. • The time spent in the group session is documented. One of the 12 group sessions may relate to the postpartum professional visit. **Childbirth and Parenting Education (Medicaid)** Childbirth and parenting education classes provided in a group classroom situation. In unusual circumstances (beneficiary entered prenatal care late or is homebound due to a medical condition) education may be provided in the member's home.	$0 copay
Health and wellness education programs These programs focused on health conditions, such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. This plan offers online and printed health education materials and tools, nutrition counseling, and disease management programs.	$0 copay
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required. In addition, we cover **Mandatory Supplemental Hearing Benefits** which include a routine hearing exam and hearing aid coverage. **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required **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.

Covered Service	What you pay
Hearing services (continued) **Hearing services (Medicaid)** • Hearing aids are covered when the member has not received a Medicaid covered hearing aid(s) within the last 5 years. A manufacturer's warranty of 24 months covering parts and labor and a 12-month warranty covering loss or damage are included • Hearing aid repairs and modifications • Replacement earmolds: Once every 12 months; after the 90-day dispensing period • Hearing aid supplies and accessories • Replacement of hearing aid batteries: Up to 36 batteries per hearing aid per date of service. Maximum of 72 batteries per aid per year • Assistive listening devices (ALDs): Covered when Medicaid has not covered any hearing aid(s) or ALD dispensed to the member within the last 3 years • Cochlear implants: Covered for members with pre or post-lingual deafness who meet the implantation criteria • Bone anchored hearing devices (BAHD): Implantable or non-implantable BAHDs when there is no other suitable aid	$0 copay *Prior authorization may be required **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.
Help with certain chronic conditions ***Special Supplemental Benefits for the Chronically Ill** **Humana Healthy Options Allowance™** **$245** monthly allowance automatically loaded on a limited-use prepaid debit card to use at participating retail locations to buy eligible products from these categories: Over the Counter (OTC) Allowance • Cold, flu and allergy • Dental and denture care • Digestive health • First aid and medical supplies • Bladder control and incontinence supplies **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Help with certain chronic conditions (continued) • Over-the-counter hearing aids • Pain relief • Skin care • Sleep aids • Smoking cessation products • Vitamins and dietary supplement, and more You will receive a new Humana Spending Account Card to access this benefit. This card is what you use to spend this allowance. Please activate your card as soon as you receive it. • The allowance is available to use at the beginning of every month. • Whatever you don't spend rolls over to the next month and expires at the end of the plan year or upon disenrollment from this plan, whichever occurs first. • Our plan is not responsible for unauthorized use of allowances due to lost or stolen cards. • As with any debit card, please keep this card in a safe place, like your wallet. • Please keep this card even after the allowance is spent as future allowance amounts may be added to this card if you remain on the plan. • Limitations and restrictions may apply. Download the free MyHumana® mobile app, available on the App Store® or Google Play®, or visit MyHumana.com to find stores or check your balance. You can also see the back of your spending account card for more information. **PLUS,** you may also be able to use this money for eligible groceries, utilities, rent, and more. If you are diagnosed with one or more qualifying chronic conditions below and have a medical claim with Humana with a date of service on or after 1/1/2021 reflecting such diagnosis, you may be eligible to receive additional benefits through the Humana Healthy Options Allowance. New claims are reviewed twice weekly for qualifying diagnosis. In some cases, members **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Help with certain chronic conditions (continued) may be able to qualify by taking a Health Risk Assessment (HRA) indicating a diagnosis of one or more eligible chronic conditions. A qualifying HRA can be found by setting up and logging into your MyHumana account. Qualifying chronic conditions: • Autoimmune disorders • Cancer • Cardiovascular disorders • Conditions associated with cognitive impairment • Conditions with functional challenges • Chronic alcohol use and other substance use disorders • Chronic and disabling mental health conditions • Chronic gastrointestinal disease • Chronic heart failure • Chronic kidney disease • Chronic lung disorders • Dementia • Diabetes mellitus • HIV/AIDS • Chronic hyperlipidemia • Chronic hypertension • Neurologic disorders • Post-organ transplant • Severe hematologic disorders • Stroke **Once you qualify**, you can buy eligible products from participating retail locations using the same money, with the same card, like: • Groceries (produce, fruit, bread, meat, dairy, etc.) **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Help with certain chronic conditions (continued) • Personal care items (toothpaste, shampoo, body soap, deodorant, etc.) • Home supplies (toilet paper, paper towels, bathroom cleaner, laundry detergent, etc.) • Household assistive devices (grab bars, raised toilet seats, reaching aids, etc.) • Pet supplies (pet food, pet litter, flea shampoo, etc.; excludes grooming services, veterinary bills, and pet prescriptions) This allowance can be used to pay for approved services, such as: • Monthly living expenses (rent/mortgage, utilities, phone, internet, etc.) • Non-medical transportation costs (public transportation, taxi, Uber, Lyft, etc.) • Personal emergency response services through the plan's approved vendor • Pest control services • Companionship care services through the plan's approved vendor • Indoor air quality equipment services *This spending allowance is a special program for members with specific health conditions. Qualifying conditions include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions and other requirements apply. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Help with certain chronic conditions (continued) **Uniformity Flexibility Non-Emergency Medical Transportation** If you are diagnosed with any of the chronic condition(s) identified below, you are eligible for the Uniformity Flexibility Non-Emergency Medical Transportation benefit. • Cancer • Chronic Kidney Disease (CKD) • End Stage Renal Disease (ESRD) This benefit offers unlimited one-way trips to all health-related, plan approved locations within the service area per calendar year, up to 50 miles per trip. Please contact Member Services for information on how to arrange transportation. Member Services will confirm your benefits and guide you to the transportation provider to plan your trip. Members must schedule trips with the transportation provider at least 72 hours (3 business days) in advance of their appointment.	$0 copay
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0 copay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Home health agency care (continued) • 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 • home health aide when provided with a nursing service	$0 copay *Prior authorization may be required
Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0 copay *Prior authorization may be required
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Hospice care (continued) expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to **Chapter 5** of this *Member Handbook*. **Note:** If you need non-hospice care, call your care coordinator and/or Member Services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis.	$0 copay

Covered Service	What you pay
Housing assistance (Medicaid) Up to $500 per member per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer Park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority	Plan approval required. • Member must not live in a residential facility or nursing facility • Funds will not be paid directly to the member • If the bill is in the spouse's name, a marriage certificate may be submitted as proof
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. This is a supplemental benefit. For additional information, please contact the Member Services number on the back of your Humana Member ID card.	$0 copay
Immunizations We pay for the following services: • pneumonia vaccine • flu/influenza shots, once each flu/influenza season, in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccine if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • other vaccines if you are at risk and they meet Medicare Part B coverage rules **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Immunizations (continued) We pay for other vaccines that meet the Medicare Part D coverage rules. Read **Chapter 6** of this *Member Handbook* to learn more. **Vaccines and immunizations (Medicaid):** Vaccines and immunizations are covered when given according to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations. This includes ACIP recommendations based on risk due to health condition, occupation, and travel. Vaccines and immunizations can be administered by providers and/or pharmacists.	$0 copay
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy **This benefit is continued on the next page.**	$0 copay You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized. *Prior authorization is required

Covered Service	What you pay
Inpatient hospital care (continued) • inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration • 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're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at 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.	$0 copay You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized. *Prior authorization is required
Inpatient services in a psychiatric hospital We will pay for up to 190 lifetime days of your admission to an inpatient psychiatric hospital. Once you have used all 190 lifetime days, you will be disenrolled from the program and your services will be covered directly by Medicaid.	$0 copay *Prior authorization is required

Covered Service	What you pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0 copay *Prior authorization may be required
Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Lung cancer screening with low dose computed tomography (LDCT) (continued) After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0 copay
Long-term acute care hospital services (LTACH) (Medicaid) Long-term acute care hospital services (LTACH) generally provide services like (but not limited to) respiratory therapy, head trauma treatment, and pain management. Member must meet level of care requirements.	$0 copay
Maternal and Infant Health Program (MIHP) services (Medicaid) MIHP services available up to 12 months postpartum. • Psychosocial and nutritional assessments • Plan of care development • Professional intervention services • Maternal and infant health and nutrition education • Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments • Referral to community services (e.g., mental health, substance abuse) • Coordination with other medical care providers • Family Planning education and referral **This benefit is continued on the next page.**	$0 copay
Maternal and Infant Health Program (MIHP) services (Medicaid) (continued) • Coordinating or providing childbirth or parenting education classes • Lactation support services	$0 copay

Covered Service	What you pay

Meals - Day trip reimbursement/allowance (Medicaid)
Medically necessary overnight stays that include meals and lodging.
• Covered for up to 14 consecutive nights (medically necessary stays beyond limits need prior approval)
• 1 medically necessary attendant
• Meals must meet one of the following:
  ○ For breakfast: The vehicle must depart before 6:00 AM and must return after 8:30 AM.
  ○ For lunch: The vehicle must depart before 11:30 AM and must return after 2:00 PM.
  ○ For dinner: The vehicle must depart before 5:30 PM and must return after 8:00 PM.
• Meal reimbursement requires itemized, unaltered receipts which must include the business name, address, date, time, and itemized list of items purchased with cost of each item.
• Meals must be purchased and consumed on the day and within the time of travel
	$0 copay

Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when referred by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. **This benefit is continued on the next page.**	$0 copay
Medical nutrition therapy (continued) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year. We may approve additional services if medically necessary.	$0 copay

Covered Service	What you pay
Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery 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 our plan authorized • the Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV) • 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. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • 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.) As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Medicare Part B drugs (continued) • 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 covered under Medicare Part B • calcimimetic and phosphate binder 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 ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.humana.com/PAL We also cover some vaccines under our Medicare Part B and most adult vaccines under our Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	$0 copay *Prior authorization may be required

Covered Service	What you pay
Routine Medical Transportation Members receive up to 48 one-way trips per year, with each trip limited to 50 miles or less. Transportation is not for emergencies and these trips may include a car, shuttle, or van service. Members must schedule transportation at least 72 hours, or 3 business days, before the appointment. Members should contact Member Services for help identifying their plan's transportation provider and arranging service. **Non-Emergency Medical Transportation** Unlimited transportation for you to travel to or from your medical appointments and the pharmacy, if it's a covered service through your Michigan Medicaid. Types of non-emergency transportation include: • Wheelchair Equipped Van • Service Car • Taxicab • Rideshare Services • Bus / Subway **Extra Transportation Benefit** You receive 15 round trips or 30 one-way rides each year for non-medical transportation, through your Michigan Medicaid. Each ride can be up to 30 miles. Some of the places you can use non-medical transportation include: • Wellness classes • Parks • Recreation centers • Church	$0 copay *Prior authorization may be required

Covered Service	What you pay
Nurse Advice Call Line (HumanaFirst®) If you have questions about symptoms you're experiencing but aren't sure if you need to use your doctor, Humana can help. Call HumanaFirst, our advice line for members, 24-hours a day, seven days a week at 866-220-4102 (TTY: 711). The call is free. It's staffed by nurses who can help address your immediate health concerns and answer questions about particular medical conditions.	$0 copay
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given 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 • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. The allowable amount is based on each person's situation and is determined when a person applies for assistance with paying a nursing facility. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility doesn't apply to Medicare-covered days in a nursing facility.

Covered Service	What you pay
Nursing facility care (continued) • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital. • the nursing home where you were living when you enrolled in Humana Dual Integrated (HMO D-SNP) This service is intended to be long term custodial care and doesn't overlap with skilled nursing facility care. You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service. **Nursing facility mental health monitoring (Medicaid)** Follow-up treatment in response to emerging problems or needs of a nursing facility resident. This service is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the member. **Nursing facility services - Institutions for mental diseases (Medicaid)** Covered for member age 65 and older. • Bed and board, including a private room, if medically necessary, and special dietary services **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. The allowable amount is based on each person's situation and is determined when a person applies for assistance with paying a nursing facility. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility doesn't apply to Medicare-covered days in a nursing facility.

Covered Service	What you pay
Nursing facility care (continued) • Nursing care, other medical services related to nursing care, and use of equipment that is owned by the facility and is ordinarily provided in the care and treatment of the patient • Specialized nursing services for patients who have been determined to be mentally ill and have other infirmities requiring nursing care • Routine physical therapy, occupational therapy and speech pathology consisting of repetitive services required to maintain function	$0 copay *Prior authorization may be required When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. The allowable amount is based on each person's situation and is determined when a person applies for assistance with paying a nursing facility. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility doesn't apply to Medicare-covered days in a nursing facility.
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. **Weight Reduction (Medicaid)** Weight loss surgery will be covered for the treatment of obesity in members with a Body Mass Index (BMI) greater than 40 kg/m², or a BMI >35 kg/m² and <40 kg/m² with at least one co-morbid condition. Treatment for obesity includes but is not limited to: • Physician office visits • Pharmacotherapy • Laboratory • Behavioral health • Surgical interventions ○ Gastric bypass, gastric band, sleeve gastrectomy, removal, revision, and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components and repeat procedures	$0 copay

Covered Service	What you pay
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 copay
Outpatient diagnostic tests and therapeutic services We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	$0 copay *Prior authorization may be required

Covered Service	What you pay
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state 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're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf**	$0 copay
Outpatient hospital services We pay for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury such as: The plan will cover the following services, and maybe other services not listed here: • services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." ○ Sometimes you can be in the hospital overnight and still be "outpatient." ○ You can get more information about being an inpatient or an outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • Labs and diagnostic tests billed by the hospital **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Outpatient hospital services (continued) • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	$0 copay *Prior authorization may be required
Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed clinical professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs). This includes outpatient mental health care. The plan will pay for the following services, and maybe other services not listed here if they're Medicare or Medicaid benefits but aren't covered by the PIHP: • clinic services • day treatment • psychosocial rehab services	$0 copay *Prior authorization may be required

Covered Service	What you pay
Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 copay *Prior authorization may be required
Outpatient substance use disorder services We will pay for outpatient substance use disorder services covered under Medicare Part B. For additional supports and services needed beyond what is covered by Medicare Part B, we will assess your needs and make a referral to your local Pre-Paid Inpatient Health Plans (PIHP) or Community Mental Health Services Provider (CMHSP) for care and treatment. This includes for outpatient substance use disorder services.	$0 copay
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0 copay *Prior authorization may be required

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. We will pay for partial hospitalization and intensive outpatient services as covered under Medicare. Additional supports and services needed beyond what is covered by Medicare will be covered by Medicaid directly.	$0 copay *Prior authorization may be required
Personal care services The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there's also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments.	$0 copay
Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) ○ physician's office ○ certified ambulatory surgical center ○ hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider **or** specialist, if your doctor orders them to find out whether you need treatment • telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • 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** **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) ○ 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, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery	$0 copay *Prior authorization may be required
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes **Podiatry services (Medicaid)** • Routine foot care when medically necessary • Debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection	$0 copay *Prior authorization may be required

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0 copay
Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months for: • a digital rectal exam • a prostate specific antigen (PSA) test	$0 copay
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic **This benefit is continued on the next page.**	$0 copay *Prior authorization may be required

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies (continued) devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision Care" later this chart for details.	$0 copay *Prior authorization may be required
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 copay
Respite You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite isn't intended to be provided on a continuous, long-term basis where it's a part of daily services that would enable an unpaid caregiver to work elsewhere full time. Respite is limited to 14 overnight stays per 365 days unless Humana Dual Integrated (HMO D-SNP) approves additional time.	$0 copay
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Screening for Hepatitis C Virus infection (continued) If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0 copay
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office. **Sexually transmitted infections (STI) treatment (Medicaid)** Outpatient services that include but are not limited to: • Diagnostic procedures, drugs, and follow-up visits to treat an STI or STI-related disorder • PAP screens and treatment for pre-cancerous conditions which commonly originate from a Sexually Transmitted Infection (STI) • Family planning-related preventive services recommended by the United States Preventive Services Task Force (USPSTF), and vaccines to prevent STIs	$0 copay
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12**. We pay for the following services, and maybe other services not listed here: **This benefit is continued on the next page.**	$0 copay

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • a semi-private room, or a private room if it is medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 copay
Stipend for maintenance costs of a service animal The plan will pay up to $20 per month for maintenance costs of a service animal if: • you're receiving personal care services, and **This benefit is continued on the next page.**	

Covered Service	What you pay
Stipend for maintenance costs of a service animal (continued) • you're certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, and • the service animal is trained to meet your specific needs relative to your disability. • your service plan must document that the service animal will be used primarily to meet your personal care needs.	

Smoking and tobacco use cessation
If you use tobacco, don't have signs or symptoms of tobacco-related disease, and want or need to quit:
• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.
Tobacco cessation counseling (Medicaid)
Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation medication or without medication.
• 4 counseling sessions per quit attempt;
• 2 quit attempts per 12 month period (8 per year);
• No limitations for pregnant women.
• Non-nicotine prescription medications
• Prescription inhalers and nasal sprays
• The following over-the-counter agents:
  ○ Patch
  ○ Gum
  ○ Lozenge
• Combination therapy – the use of a combination of medications, including but not limited to the following combinations:
This benefit is continued on the next page.
	$0 copay

Covered Service	What you pay
Smoking and tobacco use cessation (continued) ○ Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray) • Nicotine patch and inhaler • Nicotine patch and bupropion SR	$0 copay
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0 copay
Targeted Case Management (TCM) Services The plan will pay for TCM services for members who have a chronic or complex physical or behavioral health care needs and was a recent inmate or was involuntarily residing in a prison or county jail. TCM services assist members in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities (e.g., education and supports).	$0 copay

Covered Service	What you pay
Targeted Case Management (TCM) Services - Recuperative Care (Michigan Medicaid Covered) Short-term transitional program for members experiencing homelessness and are discharging from an inpatient hospital admission. Covered services include: • In-person comprehensive assessment • Planning, linking, coordinating, follow-up, and monitoring to assist the member in gaining access to services • Assistance in establishing permanent housing • Coordination with the member's primary care provider (PCP) and other providers as applicable	$0 copay
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • a an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). 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 Member Services for reimbursement. 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.	$0 copay

Covered Service	What you pay
Vision care Routine eye examinations are covered once every two years. The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids). We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for 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 50 and over • Hispanic Americans who are 65 or over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. In addition, we cover **Mandatory Supplemental Vision Benefits** which include a routine vision exam and an allowance for eyewear.	$0 copay **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.

Covered Service	What you pay
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 copay

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
Adaptive medical equipment and supplies The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include: • shower chairs/benches • lift chairs • raised toilet seats • reachers • jar openers • transfer seats • bath lifts/room lifts • swivel discs • bath aids such as long handle scrubbers • telephone aids • automated/telephone or watches that assist with medication reminders • button hooks or zipper pulls • modified eating utensils • modified oral hygiene aids • modified grooming tools • heating pads • sharps containers • exercise items and other therapy items • voice output blood pressure monitor • nutritional supplements such as Ensure	$0 copay
Adult day program The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: • provides personal attention, and promotes social, physical and emotional well-being	$0 copay *Prior authorization and/or referral may be required *Waiver may be required

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
Assistive technology The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include: • van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Chore services The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items of furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
Environmental modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Expanded community living supports To get this service, you must have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Fiscal intermediary services The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Home-delivered meals The plan covers up to two prepared meals per day brought to your home if you qualify.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
Non-medical transportation The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Personal Emergency Response System The plan covers an electronic in-home device that secures help in an emergency. You may also wear a portable "help" button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a "help" button is activated.	$0 copay
Preventive nursing services The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit to your home. These services aren't provided on a continuous basis.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required
Private Duty Nursing (PDN) The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
Respite Care Services You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite isn't intended to be provided on a continuous, long-term basis where it's a part of daily services that would enable an unpaid caregiver to work elsewhere full time.	$0 copay *Prior authorization and/or referral may be required *Waiver may be required

Mandatory Supplemental Dental Benefit DEN197

Coverage Description

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

Deductible	**$0**	
Annual Maximum	**$2,000**	
Description of Benefit	**In-Network You Pay***	**Out-of- Network You Pay**
Preventive Services		
Exams – Frequency/Limitations – 2 procedure codes per calendar year		
Periodic oral exam - D0120	0%	100%
Exams – Frequency/Limitations – 1 procedure code per calendar year		
Emergency diagnostic exam - D0140	0%	100%
Diagnostic Services – Frequency/Limitations – 1 procedure code every 3 calendar years		
Periodontal exam - D0180	0%	100%
Comprehensive exam - D0150	0%	100%
Bitewing X-rays – Frequency/Limitations – 1 set per calendar year		
Bitewing x-rays - D0270, D0272, D0273, D0274	0%	100%
Intraoral X-rays (inside the mouth)– Frequency/Limitations – 1 set per calendar year		
Periapical x-rays - D0220, D0230	0%	100%
Full Mouth or Panoramic X-rays – Frequency/Limitations – 1 procedure code every 5 calendar years		
Complete series - D0210	0%	100%
Panoramic film - D0330	0%	100%
Prophylaxis (Cleaning) – Frequency/Limitations – 2 procedure codes per calendar year		

Prophylaxis (cleaning) - D1110	0%	100%
Periodontal Maintenance – Frequency/Limitations – 4 procedure codes per calendar year		
Periodontal maintenance following periodontal therapy - D4910	0%	100%
Comprehensive Services		
Restorations (Fillings) – Amalgam and/or Composite – Frequency/Limitations – Unlimited procedure codes per calendar year		
Amalgam (silver) – primary or permanent – D2140, D2150, D2160, D2161	0%	100%
Resin-based composite (white) – anterior (front) or posterior (back) – D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	0%	100%
Scaling – Generalized Inflammation – Frequency/Limitations – 1 procedure code every 3 calendar years		
Scaling – moderate or severe gingival inflammation - D4346	0%	100%
Scaling and Root Planing – Frequency/Limitations – 1 procedure code every 3 calendar years, per quadrant		
Periodontal scaling and root planing – D4341, D4342	0%	100%
Anesthesia – Frequency/Limitations – As needed with covered codes per calendar year (in conjunction with covered services, subject to plan limitations and exclusions, subject to clinical review)		
Administration of Analgesia, anxloysis, inhalation of nitrous oxide - D9230	0%	100%
Analgesia, anxiolysis, inhalation of nitrous oxide– D9230	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 annual maximum benefit coverage amount. 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).

How Payments to You or Your Dentist are Calculated

For covered dental services, we will pay as follows:

- We will determine the total covered expense.
- We will review the covered expense against the maximum benefits allowed.
- We will pay the remaining expense to you or your dentist, minus any coinsurance you owe (the procedure you received may require you to pay a percentage of the cost).

For dental claim billing purposes, the "Date of Service" (DOS) is defined as follows:

- The date teeth are prepared for fixed bridges, crowns, inlays or onlays
- The date the impression or digital scan is made for dentures or partials
- The date the impression or digital scan of the abutment/implant is taken for implant crowns
- The date the pulp chamber of a tooth is opened for root canal therapy
- The date periodontal surgery is performed
- The date the service is performed for services not listed above

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

Submitting Pretreatment Plans

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

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

Mandatory Supplemental Hearing Benefit HER945

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

Description of Benefit	In-Network You Pay*

• Routine Hearing Exam (1 per year)
• Up to 2 TruHearing-branded prescription hearing aids every 3 years (1 per ear every 3 years).
• Benefit is limited to the TruHearing Advanced prescription hearing aids, which come in various styles and colors.
• Advanced hearing aids are available in rechargeable style options.
• **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).**
• In-network hearing aid purchase includes:
  ○ Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase
  ○ 60-day trial period
  ○ 3-year extended warranty
  ○ 80 batteries per aid for non-rechargeable models
• Benefit does not include or cover any of the following:
  ○ OTC hearing aids
  ○ Ear molds
  ○ Hearing aid accessories
  ○ Additional provider visits
  ○ Additional batteries (or batteries when a rechargeable hearing aid is purchased)
  ○ Hearing aids that are not TruHearing-branded Advanced hearing aids
  ○ Costs associated with loss & damage warranty claims
	$0
	$0 per Advanced Aid

Costs associated with excluded items are the responsibility of the member and are not covered by the plan.

Mandatory Supplemental Benefit VIS788

Description of Benefit	In-Network You Pay*
• Routine Eye Exam including refraction (1 per calendar year) by a **Humana Medicare Insight Network** optical provider OR • A refraction exam (1 per calendar year), instead of a routine eye exam, when completed at the same appointment as a Medicare covered comprehensive eye exam by a Humana network medical optical provider.	**$0*** **OR** **$0** for refraction exam in addition to the Medical Specialist cost-share for the medical exam
• Eyewear Benefit (1 per calendar year) at a Humana Medicare Insight Network optical provider • $400 allowance toward the purchase of frame and a pair of lenses OR toward the purchase of contact lenses (conventional or disposable) Benefit does not include contact lens fitting. Ultraviolet protection, scratch-resistant coating, and other lens options may be applied toward the eyeglass allowance benefit. Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan-approved amount. **The benefit can only be used one time. Any remaining benefit dollars do not "roll over" to a future purchase.**	Any retail amount over **$400**

*Your routine exam charge will not exceed **$0** at a **Humana Medicare Insight Network** optical provider. Please inform the network provider that you are part of the Humana Medicare Insight Network. **NOTE:** The network of providers for your supplemental vision benefits through Humana Medicare Insight Network may be different than the network of providers for the Medicare-covered vision benefits. The provider locator for routine vision can be found at **Humana.com/FindCare** > Add zip code for Search as Guest > Vision > Medicaid > Select State.

E. Our plan's visitor or traveler benefits

The HMO Travel Benefit is available to you as a member of Humana Dual Integrated (HMO D-SNP). You can already access emergency and urgently needed care when outside the service area. However, when traveling within the United States, the HMO Travel Benefit enables you to receive plan covered services, including preventive care. Covered services must be provided by providers within the Nat'l Medicare HMO/SNP network. You may use "Find a Doctor" on Humana.com or contact Member Services for assistance in locating a network provider when using the HMO Travel Benefit. If you receive care from a provider within the Nat'l Medicare HMO/SNP network, you will pay the same in-network copay or coinsurance you would pay if you received care within your home service area.

If you are planning to travel outside of your service area and anticipate needing to use the HMO Travel benefit, it is recommended that you notify your primary care provider. It is also recommended that you check to see if the provider or providers you wish to see while traveling are in the Nat'l Medicare HMO/SNP network using "Find a Doctor" on Humana.com or contact Member Services for assistance.

F. Benefits covered outside of our plan

We don't cover Medicaid Specialty Behavioral Health Services, but they're available through regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs).

If you're receiving services through the PIHP, please refer to the separate PIHP Member Handbook for more information and work with your Care Coordinator to get services provided through the PIHP.

G. Benefits not covered by our plan, Medicare, or Michigan Medicaid

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Michigan Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and necessary," according to Medicare and Michigan Medicaid standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare or a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community
- surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it
- a private room in a hospital, except when it is medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or a television
- full-time nursing care in your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed

- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Radial keratotomy, LASIK surgery, and other low-vision aids. However, the plan will pay for glasses after cataract surgery
- Reversal of sterilization procedures
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.

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).
- Services received from an out-of-network dentist are not covered benefits.
- Services and American Dental Associate (ADA) codes that are not listed in the Dental Mandatory Supplemental Benefit grid are not covered.
- Member is responsible for any costs for services once the annual maximum has been reached.
- Your failure to keep an appointment with the dentist.
- Charges for:
    - Any type of implant and all related services, including crowns or the prosthetic device attached to it
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- 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.
- Cosmetic services including teeth whitening.

- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- 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.
- 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:

- Over-the-counter (OTC) hearing aids.
- 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, hearing aid accessories, 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 orMedicaid).
    - 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.

Chapter 5: Getting your outpatient drug plan

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Michigan Medicaid. **Chapter 6** of this *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

We also cover the following drugs, although they're not be discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section D** "If you're in a Medicare certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another network provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription (Refer to Section A1 for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the *Drug List* for short. (Refer to Section B of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9,** Section F of this *Member Handbook*, to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** in this Chapter, for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

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

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

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

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Member Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Member Handbook*.
- If you need help getting a prescription filled, contact your Care Coordinator or Member Services.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services or your care coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan’s network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or care coordinator.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service allows you to order up to a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

Usually, a mail-order prescription arrive within 10 business days from when you 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.

Mail-order processes

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

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

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

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

   After the pharmacy gets a prescription from a healthcare provider, it contacts you to find out if you want the medication filled immediately or at a later time.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including

strength, amount, and form) and, if needed, allow you to stop or delay the order before it's shipped.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m.. The call is free.

3. 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 start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m.. The call is free.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. by calling Member Services at 855-281-6070 (TTY: 711). We're available Monday - Friday, from 8 a.m. - 8 p.m.. The call is free.

A7. Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can

give you a long-term supply of maintenance drugs. You can also call your care coordinator Member Services for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check first with Member Services to find out if there's a network pharmacy nearby.

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

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

A9. Paying you back for a prescription

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

You may be required to pay the difference between what we would pay for the drug at the out-of-network pharmacy and the cost we could cover at an in-network pharmacy.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

B. Our plan's *Drug List*

We have a *List of Covered Drugs*. We call it the *Drug List* for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under your Michigan Medicaid.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological

products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products 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.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Check the most recent *Drug List* we sent you in the mail.
- Visit our plan's website at **Humana.com/PlanDocuments**. The *Drug List* on our website is always the most current one.
- Call your care coordinator or Member Services to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" (by visiting **Humana.com** and logging into MyHumana) to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call your care coordinator or Member Services.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*.

For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Michigan Medicaid drugs) can't pay for a drug that Medicare Part A or Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use". Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Michigan Medicaid can't cover the types of drugs listed below.

- 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 made by a company that says you must have tests or services done only by them.

Please refer to the plan's Drug List or call Member Services for more information.

B4. *Drug List* cost-sharing tiers

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

- Cost-Sharing Tier 1 - Preferred Generic: Generic or brand drugs that are available at the lowest cost-share for this plan.
- Cost-Sharing Tier 2 - Generic: Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs.
- Cost-Sharing Tier 3 - Preferred Brand: Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs.
- Cost-Sharing Tier 4 - Non-Preferred Drug: Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs.
- Cost-Sharing Tier 5 - Specialty Tier: Some injectables and other high-cost drugs.

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

Chapter 6 of this *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain drugs, special rules limit how and when the plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

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

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

1. **Limiting use of a brand-name drug or original biological products when a generic or interchangeable biosimilar version is available**

   Generally, a generic or interchangeable biosimilar drug works the same as a brand-name drug and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand-name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

   - We usually don't pay for the brand-name drug or original biological product when there’s an available generic version.
   - However, if your provider has told us the medical reason that the generic or interchangeable biosimilar drug or original biological product won't work for you ***or*** wrote “No substitutions” on your prescription for a brand-name drug or original biological product ***or*** has told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand-name drug.
   - Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don’t get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at **Humana.com** for more information about prior authorization.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than

Drug B, we may require you to try Drug A first.

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at **Humana.com** for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

   To find out if any of the rules above apply to a drug you take or want to take, check the *Drug List*. For the most up-to-date information, call Member Services or check our website at **Humana.com**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook*.

D. Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

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

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

1. The drug you've been taking:
   - is no longer on our *Drug List*, **or**
   - was never on our *Drug List*, **or**
   - is now limited in some way.
2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You are new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan**.
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - Transition supply for current members with changes in treatment setting
    - Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:
      - Members who are discharged from a hospital or skilled-nursing facility to a home setting
      - Members who are admitted to a hospital or skilled-nursing facility from a home setting
      - Members who transfer from one skilled-nursing facility to another and are served by a different pharmacy
      - Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit
      - Members who give up hospice status and revert back to standard Medicare Part A and B coverage
      - Members discharged from chronic psychiatric hospitals with highly individualized drug regimens
  - To ask for a temporary supply of a drug, call Member Services at 1-800-787-3311 (TTY: 711), Monday
  - – Friday, from 8 a.m. – 8 p.m. Central time. The call is free.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

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

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't our *Drug list* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

For Michigan Medicaid drugs:

You're new to the plan.

We'll cover a supply of your Michigan Medicaid drug for up to 90 calendar days after enrollment and won't terminate it at the end of the 90 calendar days without advance notice to you and a transition to another drug, if needed.

D3. Asking for an exception

If a drug you take will be taken off the *Drug List* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this *Member Handbook*.

If you need help asking for an exception, contact your Care Coordinator or Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug. (permission from us before you can get a drug.)
- Add or change the amount of a drug you can get (quantity limits.)
- Add or change step therapy restrictions on a drug (you must try one drug before we will cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List*. For more information on these drug rules, refer to **Section C**.

If you take a drug that was covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

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

What happens if coverage changes for a drug you're taking?

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

- Check our current *Drug List* online at **Humana.com/PlanDocuments** or
- Call Member Services at the number at the bottom of the page to check our current *Drug List*.

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

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

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or be lower.

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

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.
- Tell you at least 30 days before we make the change to the *Drug List* **or**
- Let you know and give you a 30-day supply of the brand name drug or original biological product after you ask for a refill.

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

- If you should switch to the generic or interchangeable biosimilar or if there's a similar drug on the *Drug List* you can take instead, **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9,** Section F.

- **Removing unsafe drugs and other drugs that are taken off the market.** Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List.* If you're taking the drug, we'll send you a notice after we make the change.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the Drug List that don't affect you during this plan year

We may make changes to the drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the beginning of the year, we generally don't remove or change coverage of that **drug during the rest of the year.**

For example, if we remove a drug you're taking increase what you pay for the drug, or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. Youwon't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

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

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services.

F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

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

- may not be needed because you are taking another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to

- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

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

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members that qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have any questions about these programs, contact Member Services or your care coordinator.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids 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 prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, 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, limitations may include:

- Requiring you to get all 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'll cover for you.

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any 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'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If appeal, we will review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

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

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

Introduction

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

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid

Because you're eligible for Michigan Medicaid, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

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

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

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

- Our *List of Covered Drugs*.
  - We call this the "*Drug List*." It tells you:
    - Which drugs we pay for
    - Which of the five tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at **Humana.com/PlanDocuments**.
- **Chapter 5** of this *Member Handbook*.
  - It tells how to get your outpatient drugs through the plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your care coordinator or Member Services for more information.
- Our *Provider and Pharmacy Directory*:
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies

are pharmacies that agree to work with us.

- The *Provider and Pharmacy Directory* lists network pharmacies. Refer to **Chapter 5** of this *Member Handbook* more information about network pharmacies.

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A. *The Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It

includes what the plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When available, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*.

B. How to keep track of your drug costs

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

1. Use your Member ID Card.

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

2. Make sure we have the information we need.

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

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

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

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.

3. Send us information about the payments others make for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. Check the EOBs we send you.

When you get an EOB in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Humana Dual Integrated (HMO D-SNP) Member Services.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Humana Dual Integrated (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- Michigan you can report fraud by calling toll free at 855-MI-FRAUD (643-7283) Monday - Friday, 8:00 am to 5:00 pm. You can also submit an online complaint at www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse and you may find information on our website at www.michigan.gov/mdhhs/inside-mdhhs/office-of-inspector-general/contact-us, or you can write to the inspector general at
  Office of Inspector General
  PO Box 30062
  Lansing, MI 48909.

If you think something is wrong or missing, or if you have any questions, call your care coordinator or Member Services. Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are

the two stages:

Stage 1: Initial Coverage Stage

During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.

Stage 2: Catastrophic Coverage Stage

During this stage, we pay all of the costs of your drugs through 12/31/2026.

You begin this stage when you've paid a certain amount of out-of-pocket costs.

C1. Our plan has 5 cost sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our Drug List is in one of the 5 cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Cost-Sharing Tier 1 - Preferred Generic: Generic or brand drugs that are available at the lowest costshare for this plan. The copay is $0-$30, depending on your income.
- Cost-Sharing Tier 2 - Generic: Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs. The copay is $0-$60, depending on your income.
- Cost-Sharing Tier 3 - Preferred Brand: Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs. The coinsurance is 0%-25%, depending on your income.
- Cost-Sharing Tier 4 - Non-Preferred Drug: Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs. The coinsurance is 0%-25%, depending on your income.
- Cost-Sharing Tier 5 - Specialty Tier: Some injectables and other high-cost drugs. The coinsurance is 0%-32%, depending on your income

C2. Your pharmacy choices

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

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

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.

- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of this *Member Handbook* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Member Handbook* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 of this *Member Handbook*, or the *Provider and Pharmacy Directory*.

C4. What you pay

If you receive Extra Help for your drugs, your cost share may vary depending on what level of Extra Help you receive.

Prior to reaching your annual $2,100 out-of-pocket limit, you will pay:

- $5.10 for generic/preferred multi-source drug or biosimilar; $12.65 for any other drug; OR
- $1.60 for generic/preferred multi-source drug or biosimilar; $4.90 for any other drug; OR
- $0 for all drugs

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price. Contact Member Services to find out how much your copay is for any covered drug.

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

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy*** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 Preferred Generic	$0 copay	$0 copay, $10 copay, or $30 copay depending on pharmacy location and day supply	$0 copay	$0 copay
Cost-sharing Tier 2 Generic	$0 copay	$0 copay, $20 copay, or $60 copay depending on pharmacy location and day supply	$0 copay	$0 copay
Cost-sharing Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy*** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 4 Non-Preferred Drug	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 5 Specialty Tier	32% coinsurance for a one-month supply. A long-term supply is not available for drugs in Tier 5	32% coinsurance for a one-month supply. A long-term supply is not available for drugs in Tier 5	32% coinsurance for a one-month supply. A long-term supply is not available for drugs in Tier 5	32% coinsurance for a one-month supply. A long-term supply is not available for drugs in Tier 5

*You pay the in-network cost share (listed in the out-of-network cost-sharing column) plus the difference between the in-network cost and the out-of-network cost for covered prescription drugs received from a non-network pharmacy.

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

D. Stage 1: The Initial Coverage Stage

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

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Cost-Sharing Tier 1 - Preferred Generic: Generic or brand drugs that are available at the lowest costshare for this plan. The copay is $0-$30, depending on your income.
- Cost-Sharing Tier 2 - Generic: Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs. The copay is $0-$60, depending on your income.
- Cost-Sharing Tier 3 - Preferred Brand: Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs. The coinsurance is 0%-25%, depending on your income.
- Cost-Sharing Tier 4 - Non-Preferred Drug: Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs. The coinsurance is 0%-25%, depending on your income.
- Cost-Sharing Tier 5 - Specialty Tier: Some injectables and other high-cost drugs. The coinsurance is 0%-32%, depending on your income

D1. Your pharmacy choices

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

- A network retail pharmacy or
- An out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.

Our plan's mail-order pharmacy

To learn more about these choices, refer to Chapter 5 of this Member Handbook and to our Provider and Pharmacy Directory.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Member Handbook* or our plan's Provider and Pharmacy Directory.

D3. What you pay

If you receive Extra Help for your drugs, your cost share may vary depending on what level of Extra Help you receive.

Prior to reaching your annual $2,100 out-of-pocket limit, you will pay:

- $5.10 for generic/preferred multi-source drug or biosimilar; $12.65 for any other drug; OR
- $1.60 for generic/preferred multi-source drug or biosimilar; $4.90 for any other drug; OR
- $0 for all drugs

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

Contact Member Services to find out how much your copay is for any covered drug.

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

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A one-month or up to a 30-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy*** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 Preferred Generic	$0 copay	$0 copay or $10 copay	$0 copay	$0 copay
Cost-sharing Tier 2 Generic	$0 copay	$0 copay or $20 copay	$0 copay	$0 copay
Cost-sharing Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 4 Non-Preferred Drug	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 5 Specialty Tier	32% coinsurance	32% coinsurance	32% coinsurance	32% coinsurance

*You pay the in-network cost share (listed in the out-of-network cost-sharing column) plus the difference between the in-network cost and the out-of-network cost for covered prescription drugs received from a non-network pharmacy.

Your costs for a long-term (up to a 100-day) supply of a covered Part D drug

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**Preferred mail-order cost sharing (in-network)** Up to a 100-day supply
Cost-sharing Tier 1 Preferred Generic	$0 copay	$0 copay or $30 copay	$0 copay
Cost-sharing Tier 2 Generic	$0 copay	$0 copay or $60 copay	$0 copay
Cost-sharing Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 4 Non-Preferred Drug	25% coinsurance	25% coinsurance	25% coinsurance

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**Preferred mail-order cost sharing (in-network)** Up to a 100-day supply
Cost-sharing Tier 5 Specialty Tier	A Long-term supply is not available for drugs in Tier 5.		

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,100**. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the **$2,100** limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **$2,100** for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

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

Usually, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.
- When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.

- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,

- Coordinate refills with other drugs you take,
- and Take fewer trips to the pharmacy.

G. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

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

G1. What you need to know before you get a vaccine

We recommend that you call your care coordinator or Member Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and explain your share of the cost
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

G2. What you pay for a vaccine covered by Medicare Part D

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

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's *Drug List*. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

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

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you'll pay nothing.
   - For other Part D vaccines, you pay nothing or a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing or a copay to the doctor for the vaccine.

- Our plan pays for the cost of giving you the shot.
- The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing or a copay for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing or a copay for the vaccine.
   - Our plan pays for the cost of giving you the shot.

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

Introduction

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

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A. Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs after you get them. A network provider is a provider who works with the health plan.

We don’t allow Humana Dual Integrated (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don’t pay the bill and send the bill to us. To send us a bill, refer to Section B.

- If we cover the services or drugs, we’ll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
    - If you paid for services covered by Medicare, we’ll pay you back.
    - If you paid for services covered by Michigan Medicaid we can’t pay you back, but the provider will. Member Services or your care coordinator can help you contact the provider’s office. Refer to the bottom of the page for the Member Services phone number.
- If we don’t cover the services or drugs, we’ll tell you.

Contact your Care Coordinator or Member Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got includes:

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

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we'll pay the provider directly.
  - If you already paid for the Medicare service, we'll pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call your Care Coordinator or Member Services at the number at the bottom of this page if you get any bills**.

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Please refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.
- 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'd pay at an in-network pharmacy.

5. When you pay the full prescription cost because you don't have your Member ID Card with you

If you do not have your Humana Dual Integrated (HMO D-SNP) Member ID Card with you, you can ask the

pharmacy to call us or to look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full cost of the prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- 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 prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs (Drug List)*, on our website or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

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

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Member Handbook*.

B. Sending us a request for payment

Send us your bill and proof of any payment you have made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help. You must send your information to us within 90 days of the date you receive the service, item, or drug.

To make sure you are giving us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get a copy of the form on our website **Humana.com**, or you can call Member Services and ask for the form.

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

Humana
PO Box 14359
Lexington, KY 40512-4359

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you have already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay our share of the cost of for service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9,** Section D.

D. Appeals

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

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Member Handbook*:

- To make an appeal about getting paid back for a healthcare service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G.**

Chapter 8: Your rights and responsibilities

Introduction

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

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapability, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call your care coordinator or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large

- print, braille, or audio. To get materials in one of these alternative formats, please call Member Services or write to Humana Dual Integrated (HMO D-SNP), PO Box 14359, Lexington, KY 40512-4359. Spanish materials are available upon request. You can make a standing request to get materials, now and in the future, in a language other than English. We will keep your preferred language other than English and/or alternate formate for future mailings and communications. You will not need to make a separate request each time. Call Member Services if you want to change your standing request.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- **You may file a complaint with Michigan Medicaid by doing the following:**
  - Fill out the Beneficiary Complaint Form (BCF) online at www.michigan.gov/mdhhs/assistance-programs/healthcare/beneficiary-support/msa-0300-online-form.
  - Submitting online will send an email with your BCF to the Beneficiary Support Unit. Print and complete the Beneficiary Complaint Form (MSA-0300).
  - Follow the instructions on the form and then mail it to the address shown below:
    Michigan Department of Health and Human Services
    Health and Aging Services Administration
    Customer Services Division
    PO Box 30479
    Lansing, MI 48909-7979
  - If you have questions about the Beneficiary Complaint form or this process, call the **Beneficiary HelpLine** at **1-800-642-3195.**
- The Michigan Office of Recipient Rights (ORR) is a state agency that investigates allegations of violations of rights established by the Michigan Mental Health Code.
  - You may file by complaint by contacting the MCCMH-ORR at (586) 469-6528. Our business hours are 8:30 am – 5:00 pm, Monday through Friday. You may also leave a message during non-business hours and staff will contact you during normal business hours.
  - You may also fill out a Recipient Rights Complaint form and either mail, fax or e-mail it.
- Office of Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

Usted tiene derecho a recibir servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que **todos** los servicios, tanto clínicos como no clínicos, se le proporcionen de una manera culturalmente competente y accesible, incluso para aquellos con dominio limitado del inglés, habilidades de lectura limitadas, incapacidad auditiva o aquellos con diversos orígenes culturales y étnicos. También debemos informarle sobre los beneficios del plan y sus derechos de una forma que usted pueda comprender. Tenemos que informarle sobre sus derechos cada año que usted sea afiliado de nuestro plan.

- Para obtener información en una forma que pueda comprender, llame a su coordinador de cuidado o a Atención al Cliente. Nuestro plan cuenta con servicios gratuitos de intérpretes disponibles para responder preguntas en diferentes idiomas.

- Nuestro plan también puede proporcionarle sus materiales en otros idiomas, además de español, y en formatos tales como letra grande, Braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Atención al Cliente o escriba a Humana Dual Integrated (HMO D-SNP), PO Box 14359, Lexington, KY 40512-4359. Existen materiales en español disponibles a solicitud. Puede hacer un pedido permanente para recibir los materiales, ahora y en el futuro, en un idioma que no sea inglés. Conservaremos su idioma preferido que no sea inglés y/o un formato alternativo para futuras comunicaciones y correspondencia. No tendrá que hacer una solicitud por separado cada vez. Llame al Servicio de Atención al Cliente si desea cambiar su solicitud permanente.

Si tiene dificultades para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad, y quiere presentar una queja, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- **Puede presentar una queja ante Michigan Medicaid de la siguiente manera:**
    - Complete el Formulario de Queja del Beneficiario (BCF, por sus siglas en inglés) en línea en www.michigan.gov/mdhhs/assistance-programs/healthcare/beneficiary-support/msa-0300-online-form.
    - Si presenta la queja en línea, se enviará un correo electrónico con su BCF a la Unidad de Apoyo al Beneficiario. Imprima y complete el Formulario de Queja del Beneficiario (MSA-0300).
    - Siga las instrucciones del formulario y luego envíelo por correo a la dirección que se muestra a continuación:

      Michigan Department of Health and Human Services

      Health and Aging Services Administration

      Customer Services Division

      PO Box 30479

      Lansing, MI 48909-7979
    - Si tiene preguntas sobre el Formulario de Queja del Beneficiario o este proceso, llame a la **Línea de Ayuda para Beneficiarios** al **1-800-642-3195**.

La Oficina de Derechos de los Beneficiarios de Michigan (ORR, por sus siglas en inglés) es una agencia estatal que investiga las denuncias de violaciones de los derechos establecidos por el Código de Salud Mental de Michigan.

- Puede presentar una queja llamando a MCCMH ORR al (586) 469-6528. Nuestro horario de atención es de lunes a viernes de 8:30 a.m. a 5:00 p.m. También puede dejar un mensaje fuera del horario comercial y el personal se comunicará con usted durante el horario comercial normal.
- También puede completar un formulario de Queja sobre los Derechos del Beneficiario y enviarlo por correo, fax o correo electrónico.

Llame a la Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.
  - Call Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Member Handbook*.

Chapter 9 of this *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people do not look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies that are checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws. Michigan Medicaid may disclose your information without your permission for purposes of treatment, payment, health care operations or when required by law to do so.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services. If you don't speak English, we have interpreter services to answer questions you have about our health plan. To get an interpreter, just call Member Services. This is a free service to you. You may contact Member Services to request plan materials in any language. Please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit **MyHumana.com** for 24-hour access to information such as claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information. We can also give you information in large print, braille, or audio. You can request alternative formats by calling Member Services.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave the plan
- Our network providers and our network pharmacies, including:

- how to choose or change primary care providers
- qualifications of our network providers and pharmacies
- how we pay providers in our network

- Covered services and drugs including:
  - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by the plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook*:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your Michigan Medicaid benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand.

You have the right to:

- **Know your choices.** You have the right to be told about all treatment options
- **Know the risks.** You have the right to be told about any risks involved. You must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

In Michigan, you can create a legal document called a **Durable Power of Attorney for Health Care (DPOA-HC).** This document allows you to name a **patient advocate** who can make medical decisions for you if you become incapacitated and can't make your own decisions. The DPOA-HC may include an "Advance Directive" as described below.

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

- Fill out a written form **giving someone the right to make health care decisions for you if you ever become unable to make decisions for yourself.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

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

You aren't required to have an advance directive, but you can. Here is what to do if you want to use an advance directive:

- Healthcare Power of Attorney-This lets you pick someone to make your health care decisions if you're too sick to decide for yourself.
- Living Will-This tells your doctor and other providers what type of care you want if you're terminally ill and you won't get better.
- Mental Health Preference- This lets you decide if you want to receive some types of mental health treatments that might be able to help you.

- Do Not Resuscitate (DNR) Order -This tells your family and all your doctors and other providers what you want to do in case your heart or breathing stops.

You can get more information on advance directives from your health plan or your doctor. If you're admitted to the hospital they might ask you if you have one. You don't have to have one. You don't have to have one to get your medical care but most hospitals encourage you to have one. You can choose to have any one or more of these advance directives if you want and you can cancel or change it at any time

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get a form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the forms.
- **Fill it out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to 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're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive, and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems at 1-800-882-6006.

H. Your right to make complaints and to ask us to reconsider our decisions

Chapter 9 of this *Member Handbook* tells what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services
- The MI SHIP MI Options program at 800-803-7174 (TTY 711). For more details about MI SHIP MI Options, refer to **Chapter 2**
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24-hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- Medicaid Customer Help - MSA/MDHHS at 1-800-642-3195. For Michigan calls only, call 1-800-642-3195.

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapter 5 and Chapter 6** of this *Member Handbook*.
- **Tell us about any other health or prescription drug coverage** you have**.** We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 855-281-6070, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. The call is free. **For more information**, visit **Humana.com**.

- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Humana Dual Integrated (HMO D-SNP) members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - For some of your drugs covered by our plan, you must pay your share of the cost when you get the drug. This will be a copayment. **Chapter 6** of this *Member Handbook* tells you what you must pay for your drugs.
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** if you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and Michigan Medicaid your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Michigan Medicaid.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board)**.
- **Call Member Services for help if you have questions or concerns.**

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

Introduction

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

You have a problem with or complaint about your plan.

- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, long-term supports and services, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and Humana Dual Integrated (HMO D-SNP) first. **If you're still having a problem with your care or our plan, you can call the MI Community, Home, and Health Ombudsman (MI CHHO) at 1-888-746-6456.** This chapter explains the different options you have for different problems and complaints, but you can always call the MI Community, Home, and Health Ombudsman (MI CHHO) to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to Chapter 2 for more information on ombudsman programs.

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If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 855-281-6070, (TTY: 711), Monday – Friday, from 8 a.m. – 8 p.m. The call is free. **For more information**, visit **Humana.com**.

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A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

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

For example, we say:

- "Making a complaint" instead of "filing a grievance"
- "Coverage decision" instead of "organization determination", "benefit determination", "at-risk determination", or "coverage determination"
- "Fast coverage decision" instead of "expedited determination"
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

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

B. Where to get help

B1. For more information and help

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

Help from the Michigan State Health Insurance Assistance Program (SHIP)

You can call the Michigan State Health Insurance Assistance Program (SHIP). Michigan State Health Insurance Assistance Program (SHIP) counselors can answer your questions and help you understand what to do about your problem. Michigan State Health Insurance Assistance Program (SHIP) isn't connected with us or with any insurance company or health plan. Michigan State Health Insurance Assistance Program (SHIP) has trained counselors in every county, and services are free. The Michigan State Health Insurance Assistance Program (SHIP) phone number is 1-800-803-7174.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from Michigan Medicaid

You can call the Beneficiary Help Line at 1-800-642-3195 from 8:00 AM to 7:00 PM Monday through Friday (except holidays) or email beneficiarysupport@michigan.gov. The Beneficiary Support website can be found at www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/supportht.

C. Understanding Medicare and Michigan Medicaid complaints and appeals in our plan

You have Medicare and Michigan Medicaid. Information in this chapter applies to all your Medicare and Michigan Medicaid benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Michigan Medicaid processes.

Sometimes Medicare and Michigan Medicaid processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a Michigan Medicaid benefit. **Section F4** explains these situations.

D. Problems with your benefits

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

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes.	**No.**
My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care**.

NOTE: Medicaid specialty behavioral health services are covered by the Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. If the PIHP makes a coverage decision and you don't agree with it, you must appeal to the PIHP.

Information about the PIHP in your area is found **Chapter 4** of this *Member Handbook*.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section H** of this *Member Handbook*).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Michigan Medicaid. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

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

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- Call your **Care Coordinator** at 855-281-6070.
- **Member Services** at the numbers at the bottom of the page.
- MI SHIP MI Options at 800-803-7174 (TTY 711). For more information or to find a local MI Options

office in your area, please visit www.michigan.gov/MDHHSMIOptions.

- Call the **MI Community, Home, and Health Ombudsman (MI CHHO)** for free help. The MI Community, Home, and Health Ombudsman (MI CHHO) can help you with questions about or problems with the MICH program or our plan. The MI Community, Home, and Health Ombudsman (MI CHHO) is an independent program, and is not connected with this plan. The phone number is 1-888-746-6456.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
- **Michigan Long Term Care Ombudsman Program (MLTCOP)** - MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call 866-485-9393 or send us an email mltcop.org/contact.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS- Forms/CMS-Forms/downloads/cms1696.pdf **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G,** "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to Section H or Section I to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 855-281-6070, TTY: 711.
- Faxing: 888-889-9934.
- Writing: PO Box 14359 Lexington, KY 40512-4359.

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- **7 calendar days** after we get your request **for a medical service or item that's subject to our prior authorization rules.**
- **14 calendar days** after we get your request **for all other medical services or items.**
- **72 hours** after we get your request **for a Medicare Part B drug.**

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K.**

Fast coverage decision

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

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request for a medical service or item.
- **24 hours** after we get your request for a Medicare Part B drug.

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

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a

fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, 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'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 855-281-6070.

Ask for a standard appeal or a fast appeal in writing or by calling us at 855-281-6070.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS- Forms/downloads/cms1696.pdf
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Michigan Fair Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR). **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Michigan, Fair Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR).

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of an Michigan Medicaid service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Michigan Medicaid, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we 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 Michigan Medicaid usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Michigan Medicaid** may cover, you automatically get a Level 2 Appeal with the IRO. 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. Refer to **Section F3** of this *Member Handbook* for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Michigan Medicaid, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE.**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appea**l within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to

Section J of this *Member Handbook* for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and Michigan Medicaid

A Level 2 Appeal for services that Michigan Medicaid usually covers is a Fair Hearing with the state. In Michigan, Fair Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR). You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- 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 get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5: Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the drug categories that require a copay.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you for the

service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.

- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Michigan Medicaid usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Michigan Medicaid may cover. **This section only applies to Medicare Part D drug appeals**. We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)

- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination**".

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2,** then refer to **Sections G3 and G4.**	Refer to **Section G4**.	Refer to **Section G4**.	Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception**".

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our *Drug List***

- If we agree to make an exception and cover a drug that isn't on our *Drug List*, you pay the copay that applies to drugs in cost sharing Tier 4 - Non-preferred Drug.
- You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our *Drug List* is in one of 6 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

- Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - If the drug you take is a generic drug, you can ask us to cover it at the cost- sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5: Specialty Tier.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

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

Our *Drug List* often includes more than one drug for treating a specific condition. These are called

"alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 855-281-6070, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6**, for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

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

- We must give you our answer within 14 calendar days after we get your request.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan "**redetermination**".

- Start your **standard** or **fast** appeal by calling 855-281-6070, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the

appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**", sometimes called the "**IRE**".

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar day**s after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800- 633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.

- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1- 877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma- im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Michigan, the QIO is Commence Health. Call them at 1-888-524-9900 (TTY: 1-888-985-8775). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. **Ask for a fast review.** Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for "**fast review**" is "**immediate review**" or "**expedited review.**"

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the "**Detailed Notice of Discharge**." You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486- 2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms- notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at Toll-free Phone 1-888-524-9900.

You must ask for this review **within 60 calendar days** after the day the QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice only shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** of this *Member Handbook*, for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the MI SHIP MI Options at 800-803-7174 (TTY 711). For more information or to find a local MI Options office in your area, please visit www.michigan.gov/MDHHSMIOptions.
  - Call the **MI Community, Home, and Health Ombudsman (MI CHHO)** for free help. The MI Community, Home, and Health Ombudsman (MI CHHO) can help you with questions about or problems with the MICH program or our plan. The MI Community, Home, and Health Ombudsman (MI CHHO) is an independent program and is not connected with this plan. The phone number is 1-888-746-6456.
  - **Michigan Long Term Care Ombudsman Program (MLTCOP)** - MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call 866-485-9393 or send us an email at mltcop.org/contact.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is "**Notice of Medicare Non-Coverage**". To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486- 2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General- Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.

- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is "**Detailed Explanation of Non-Coverage**".

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

- For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. In Michigan, the Quality Improvement Organization is called Commence Health. You can reach Commence Health at: 1 888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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.

If you need assistance at any stage of the appeals process, you can contact the MI Community, Home, and Health Ombudsman (MI CHHO). The phone number is 1-888-746-6456.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Michigan Medicaid appeals

If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at 517-335-2482 for information about requirements you must meet to qualify for a rehearing/reconsideration.

If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.

Complaint	Example
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Customer Care at 1-800-457-4708 (TTY:711).

The legal term for a "complaint" is a "**grievance**."

The legal term for "making a complaint" is "**filing a grievance**."

K2. Internal complaints

To make an internal complaint, call Member Services at 1-800-787-3311 (TTY: 711). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

Grievance Filing Instructions

File a verbal grievance by calling Customer Care at 1-800-787-3311 (TTY: 711).

Humana Grievances and Appeals Dept.
P.O. Box 14163
Lexington, KY 40512– 4359

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're 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 (1-800-787-3311, TTY: 711) and ask for the Appointment of Representative form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://www.humana.com/member/documents-and-forms) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you'd 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'll 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.

The legal term for "fast complaint" is "**expedited grievance**."

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

If you need help at any stage of this process, you can contact the MI Community, Home, and Health Ombudsman (MI CHHO). The phone number is 1-888-746-6456.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Humana Dual Integrated (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486- 2048. The call is free.

You can tell Michigan Medicaid about your complaint

You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1 800-975-7630 if calling from an internet-based phone service.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818

TDD: (800) 537-7697
Email: ocrmail@hhs.gov

- You may also have rights under the Americans with Disability Act (ADA) and under the Michigan Persons with Disabilities Civil Rights Act (PWDCRA), which protects individuals with disabilities from discrimination in employment, housing, public accommodations, services, and education. You can contact the MI Community, Home, and Health Ombudsman (MI CHHO) at 1-888-746-6456 for help.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2**, or refer to **Chapter 2** of this *Member Handbook*.

In Michigan, the QIO is called Commence Health. The phone number for Commence Health is 1 888-524-9900 (TTY: 1-888-985-8775).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Michigan Medicaid programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Michigan Medicaid, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period,** which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,

- your eligibility for Michigan Medicaid or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

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

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling: Member Services at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 192.

C. How to get Medicare and Michigan Medicaid services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual- eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**Here is what to do:** 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. If you need help or more information: • Call the Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. In MI, the SHIP is called Michigan State Health Insurance Assistance Program (SHIP). **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24-hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. In MI, the SHIP is called Michigan State Health Insurance Assistance Program (SHIP). **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the MI SHIP MI Options at 800-803-7174 (TTY 711). For more information or to find a local MI Options office in your area, please visit www.michigan.gov/MDHHSMIOptions.	**Here is what to do:** 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. If you need help or more information: • Call the Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. In MI, the SHIP is called Michigan State Health Insurance Assistance Program (SHIP). You will automatically be disenrolled from our plan when your Original Medicare coverage begins.
4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A.**	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the Michigan State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. In MI, the SHIP is called Michigan State Health Insurance Assistance Program (SHIP). **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

C2. Your Michigan Medicaid services

If you leave our plan, you'll get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long-term services and supports and behavioral health care. If you leave our plan you can use any provider that accepts Michigan Medicaid.

Use MI Bridges to update your enrollment information.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your

new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Humana Dual Integrated (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our plan ends

These are the cases when we must end your membership our plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months. Since your plan has a visitor/travel benefit, you may be eligible to be outside of the service area for up to 12 months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
    - Refer to **Chapter 4** of this *Member Handbook* for information on getting care through our visitor or traveler benefits when you're away from our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid (CMS) Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

If you are within our plan's six-month period of deemed continued eligibility, you will continue to receive all benefits covered by the Medicare Advantage plan. However, during this period, you may be subject to Part D premiums and Part D cost-shares based on your level of "Extra Help." Additionally, based on your level of Medical Assistance Program eligibility, you may also be responsible for Medicare Part A and/or Part B premiums. We will continue to cover your Medicare Advantage plan covered cost-shares during this period.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

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

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1 800 MEDICARE (1 800 633 4227). TTY users should call 1 877 486 2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** in this *Member Handbook*, for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at the number on the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook.*

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C. Notice about Medicare as a second payer and Michigan Medicaid as a payer of last resort 196

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal laws about the Medicare and Michigan Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at (800) 368-1019.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and Michigan Medicaid as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Michigan Medicaid is the payer of last resort.

Notice of Privacy Practices

For your personal health information

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

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

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

What is personal and health information?

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

How do we protect your information?

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

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

How do we use and disclose your information?

We must use and disclose your information:

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

We have the right to use and disclose your information:

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

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

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

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

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

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us.

After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

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

- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision - You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application or insurance. (This right applies only to our Massachusetts residents in accordance with state regulations.)
- Alternate Communications - You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request correction of any of this personal information though amendment or deletion. Within 30 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. In the event that we refuse to amend or delete the information in the 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 for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six

years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- Notice - You have the right to receive a written copy of this notice any time you request.
- Restriction - You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

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

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

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

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

- Contacting us at 1-866-861-2762 (TTY: 711) at any time. The call is free.
- Accessing our Website at **Humana** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com
- Send completed request form to:

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

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

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 (TTY: 711), any time.

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

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

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

You have a right to receive a notice that a breach has resulted in your unsecured private information being

inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

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

Arcadian Health Plan, Inc.

CarePlus Health Plans, Inc.

Cariten Health Plan, Inc.

CHA HMO, Inc.

CompBenefits Company

CompBenefits Dental, Inc.

CompBenefits Insurance Company

DentiCare, Inc.

Emphesys Insurance Company

HumanaDental Insurance Company

Humana Benefit Plan of Illinois, Inc.

Humana Employers Health Plan of Georgia, Inc.

Humana Health Benefit Plan of Louisiana, Inc.

Humana Health Company of New York, Inc.

Humana Health Insurance Company of Florida, Inc.

Humana Health Plan of California, Inc.

Humana Health Plan of Ohio, Inc.

Humana Health Plan of Texas, Inc.

Humana Health Plan, Inc.

Humana Health Plans of Puerto Rico, Inc.

Humana Insurance Company

Humana Insurance Company of Kentucky

Humana Insurance Company of New York

Humana Insurance of Puerto Rico, Inc.

Humana MarketPOINT, Inc.

Humana MarketPOINT of Puerto Rico, Inc.

Humana Medical Plan, Inc.

Humana Medical Plan of Michigan, Inc.

Humana Medical Plan of Pennsylvania, Inc.

Humana Medical Plan of Utah, Inc.

Humana Regional Health Plan, Inc.

Humana Wisconsin Health Organization Insurance Corporation

Managed Care Indemnity, Inc.

Preferred Health Partnership of Tennessee, Inc.

The Dental Concern, Inc.

Chapter 12: Definitions of important words

Introduction

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

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24-hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Member Handbook* explains appeals, including how to make an appeal.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's 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. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

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

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *Member Handbook* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. **Chapter 9** of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

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

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

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

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications

Drug tiers: Groups of drugs on our *Drug List*. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of 5 tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

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

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function and if you're a pregnant woman, loss of an unborn child. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra help is also called the "Low-Income Subsidy," or "LIS."

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you do not understand.

Because we pay the entire cost for your services, you **don't** owe any cost sharing. Providers shouldn't bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan 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 known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

***List of Covered Drugs* (*Drug List*):** A list of prescription drugs and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

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

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health

plans, including our plan, must cover all of the services covered by Medicare Part A and Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Member Handbook* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give

you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and don’t charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who can't get their care at home but who don't need to be in the hospital.

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

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the 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): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Member Handbook* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a healthcare professional.

Part A: Refer to “Medicare Part A.”

Part B: Refer to “Medicare Part B.”

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to our Notice of Privacy Practices for more information about how we product, use and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms)

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost

sharing amounts, alternative drugs 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 drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

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 **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. 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, **877-320-1235 (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)**.

California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235（听障专线：711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235（聽障專線：711）**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French] : Des services gratuits linguistiques, d’aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]：言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

This notice is available at **https://www.humana.com/legal/multi-language-support**.

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ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)**번으로 문의하십시오.

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-́nyɔ,́kè nyɔ-bɔǔ̌n-po-kà ɓě ɓɛ́ nyuɛɛ se wíɖí pɛ́è-pɛ́è ɖò kɔ.̀ **877-320-1235 (TTY: 711)** ɖá.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọ̀wọ́tó. Pe **877-320-1235 (TTY: 711).**

नेपाली [Nepali]: भाषासम्बन्धी नि:शुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Humana Dual Integrated (HMO D-SNP) Member Services

CALL	855-281-6070 Monday - Friday, from 8 a.m. - 8 p.m.. Member Services also has free language interpreter services available for non-English speakers.
TTY	TTY: 711 Calls to this number are free. Monday - Friday, from 8 a.m. - 8 p.m..
WRITE	Humana Dual Integrated (HMO D-SNP) P.O. Box 14359 Lexington, KY 40512-4359
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