2027

Member Handbook

Humana Dual Integrated (HMO D-SNP)
This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

South Carolina

Humana. | Healthy Connections

Humana Dual Integrated (HMO D-SNP) Member Handbook

January 1, 2027–December 31, 2027

Your Medicare and Healthy Connections 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, 2027. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. 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.

When this *Member Handbook* says "we," "us," or "our," it means Humana Dual Integrated (HMO D-SNP).

This document is available for free in Spanish.

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.

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.

- Member Services if you want to make or change a standing request at 866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time.
- 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 5/31/2029)

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Disclaimers

Humana Dual Integrated (HMO D-SNP) is a health plan that contracts with both Medicare and Healthy Connections Medicaid to provide benefits of both programs to members.

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. Humana Dual Integrated (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2027 based on a review of Humana Dual Integrated (HMO D-SNP)'s Model of Care.

Limitations, copays, and restrictions may apply. For more information, call Humana Dual Integrated (HMO D-SNP) Member Service 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, 2028.

Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 1-866-432-0001, (TTY: 711), Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time. The call is free. **for more information**, visit **Humana.com.**

The Humana Healthy Options Allowance* is a special supplemental benefit(s) for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may 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.

*If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

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 South Carolina Healthy Connections 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 1-866-432-0001, (TTY: 711), Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time. 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 Healthy Connections Medicaid. Because you have Healthy Connections 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. Healthy Connections Medicaid may also provide other benefits to you by covering health care services and prescription drugs that are not usually covered under Medicare. You will 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 Healthy Connections Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

B. Information about Medicare and Healthy Connections Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Healthy Connections Medicaid

Healthy Connections Medicaid is the name of South Carolina's Medicaid program. Healthy Connections Medicaid is run by the state and is paid for by the state and the federal government. Healthy Connections 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 South Carolina must approve Humana Dual Integrated (HMO D-SNP) each year. You can get Medicare and Healthy Connections Medicaid services through our plan as long as:

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

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

C. Advantages of our plan

You'll now get all your covered Medicare and Healthy Connections Medicaid services from our plan, including drugs. **You don't pay extra to join this health plan.**

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

- You can work with us for **most** of your health care needs.
- You 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 have 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 will work with you to come up with 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) H1396-001: In most instances you'll be enrolled in Humana Dual Integrated (HMO D-SNP) H1396-001 for your Medicare benefits the 1st day of the month after you request to be enrolled in Humana Dual Integrated (HMO D-SNP) H1396-001. You may still receive your South Carolina Healthy Connections Medicaid from your previous South Carolina Healthy Connections Medicaid health plan for one additional month. After that, you'll receive your South Carolina Healthy Connections Medicaid services through Humana Dual Integrated (HMO D-SNP) H1396-001. There will be no gap in your South Carolina Healthy Connections 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 these counties in South Carolina: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton,

Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, York Counties, SC.

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 are not considered living in the service area even if they are physically located in it.), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are United States citizen or national, or an eligible non-citizen, **and**
- are currently eligible for Healthy Connections Medicaid, **and**
- are 18 years or older at the time of enrollment.

Even if you meet the above criteria, you're not eligible for our plan if you:

- are part of the Healthy Connections Medicaid spend-down population; **or**
- have Comprehensive Third Party Insurance; **or**
- live in an Intermediate Care Facility for people with Intellectual Disabilities (ICF/IID) or at the time of eligibility determination

If you lose your South Carolina Healthy Connections Medicaid eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Humana Dual Integrated (HMO D-SNP) H1396-001. When your South Carolina Healthy Connections Medicaid coverage ends, we won't pay for your South Carolina Healthy Connections Medicaid benefits. However, we will not cover your Healthy Connections Medicaid services and your Medicare cost sharing amounts. In this period of deemed continued eligibility, you can keep your Medicare benefits, but not your Healthy Connections Medicaid benefits.

We'll assist you to regain your South Carolina Healthy Connections Medicaid eligibility. If your South Carolina Healthy Connections Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your South Carolina Healthy Connections Medicaid benefits and your enrollment with us will continue. If you can't regain South Carolina Healthy Connections Medicaid within six month(s) we'll disenroll you from Humana Dual Integrated (HMO D-SNP) H1396-001. If you regain South Carolina Healthy Connections Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Call Member Services for more 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 90 days 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, including housing, transportation, and your ability to obtain food and nutrition.

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 reach out to you annually to see if any of your needs have changed.

We'll send you more information about this HRA.

If this plan is new for you, you can keep using the doctors you use now and keep your current service authorizations for up to 90 days after you first enroll. During this time period, you'll continue to have access to the same medically necessary items, services, and drugs as you do today. You'll also still have access to your medical and mental health providers. However, if a course of treatment ends or if a prior authorization expires during your first 90 days in our plan, it won't automatically be renewed.

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, your specialists, or other health professionals 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, and LTSS or other services.

Your care plan includes:

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

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:

- Monthly Medicare Part B Premium **(Section H1)**
- Medicare Prescription Payment Plan Amount **(Section H2)**

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. The "Extra Help" program helps people with limited resources pay for their drugs. 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 these programs, **the information about premiums in this *Member Handbook* may 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. 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 Healthy Connections Medicaid as well as have both Medicare Part A and Medicare Part B. For most Humana Dual Integrated (HMO D-SNP) members, 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. This includes your premium for Medicare Part B. 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.**

H2. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from our 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've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this *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* found on our website **Humana.com/plandocuments**.

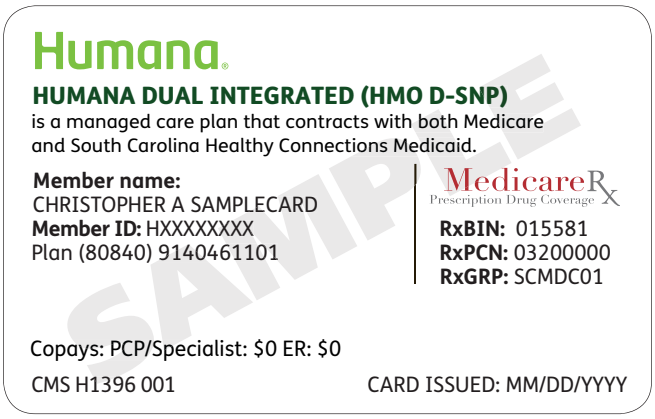
The contract is in effect for the months You're enrolled in our plan between January 1, 2027 and December 31, 2027.

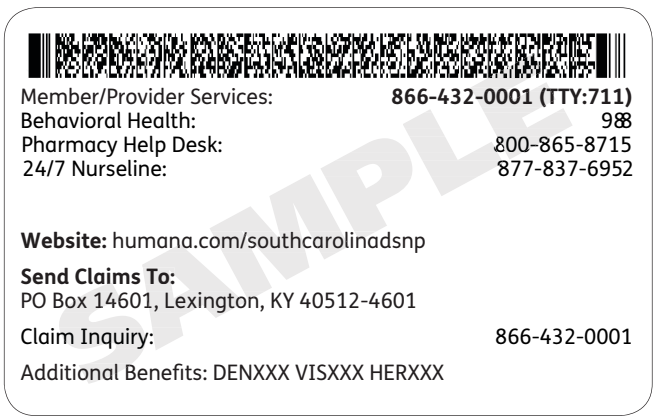
J. Other important information you get from us

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 Healthy Connections Medicaid services, including LTSS, 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 are a member of our plan, you don't need to use your red, white, and blue Medicare card or your Healthy Connections 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're 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.

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**
  - behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Healthy Connections 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 Service and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. List of Covered Drugs

Our plan has a *List of Covered Drug*s. We call it the *Drug List* for short. It tells 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've been removed and replaced as described in **Chapter 5, Section E**. 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 Member Services or visit our website at the address at the bottom of the page.

J4. The Explanation of Benefits (EOB)

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 is called the Explanation of Benefits. We call it the Explanation of Benefits.

The Explanation of Benefits tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This Explanation of Benefits isn't a bill. The Explanation of Benefits 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 Explanation of Benefits and how it helps you track your drug coverage.

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

K. Keeping your membership record up to date

You can keep your membership record 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 membership record 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 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.

Keep your Healthy Connections Medicaid information updated through the SCDHHS portal (**www.apply.scdhhs.gov/CitizenPortal/**) or by calling Healthy Connections Medicaid Member Services.

K1. Privacy of personal health information (PHI)

Information in your membership record 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	1-866-432-0001 This call is free. Member Service is available seven days a week, Oct. 1- March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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 don't 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 14601 Lexington, KY 40512-4601
WEBSITE	**Humana.com/customer-support** 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 pay for your health services.
  - Call us if you have questions about a coverage decision about your 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

- 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 D**).
- You can call us and explain your complaint at 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time.
- 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 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.
- To learn more about making a complaint about your health care, refer to **Chapter 9 o**f 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, Healthy Connections Medicaid Prescription drugs, and Healthy Connections Medicaid over-the-counter drugs.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** 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 a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your 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	1-866-432-0001 This call is free. We're available seven days a week, Oct. 1- March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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 don't 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 14601 Lexington, KY 40512-4601
WEBSITE	**Humana.com/customer-support** 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
- questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

C. Insurance Counseling Assistance and Referrals for Elders (I-CARE)

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 South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program.

I-CARE 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	1-800-868-9095 Office hours are Monday through Friday from 8:30 a.m. to 5 p.m.

TTY	TTY: 711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours of operation are the same as above.
WRITE	Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201
EMAIL	askus@aging.sc.gov
WEBSITE	**www.aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud**

Contact I-CARE for help with:

- questions about Medicare
- I-CARE 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 Acentra Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

CALL	1-888-317-0751 This call is free. Acentra Health team members are available 9 a.m. to 5 p.m. Monday through Friday and from 11 a.m. to 3 p.m. on Saturdays, Sundays, and holidays. You can also leave a message 24 hours a day, 7 days a week. Translation services are available for members and caregivers who don't speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

WRITE	Acentra Health 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	**www.acentraqio.com**

Contact Acentra 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 preventive 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. Healthy Connections Medicaid

Healthy Connections 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 Healthy Connections Medicaid. If you have questions about the help you get from Medicaid, call Healthy connections Medicaid.

CALL	1-888-549-0820 This call is free. This number is available Monday through Friday from 8 a.m. to 6 p.m.
TTY	1-888-842-3620 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202
WEBSITE	**www.scdhhs.gov**

G. South Carolina Department of Aging

The South Carolina Department of Aging 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 Department of Aging can help 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	1-800-868-9095 Office hours are Monday through Friday from 8:30 a.m. to 5 p.m.
TTY	TTY: 711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201
WEBSITE	**www.aging.sc.gov**

H. South Carolina Long Term Care Ombudsman

The South Carolina Long Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The State of South Carolina Long Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	1-800-868-9095 This call is free. Office hours are Monday through Friday from 8:30 a.m. to 5 p.m.
WRITE	Long Term Care Ombudsman Department on Aging 1301 Gervais St., Suite 350 Columbia, SC 29201
EMAIL	ltcombudsman@aging.sc.gov
WEBSITE	**www.aging.sc.gov**

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 also show it the next time you go to a pharmacy to have a prescription filled. You can use any one of the following documents to provide evidence to us, or to show as proof at the pharmacy.

Proof that you already have Extra Help status

- A letter from the Social Security Administration showing your Extra Help status. This letter could be called Important Information, Award Letter, Notice of Change, or Notice of Action.
- A letter from the Social Security Administration showing that you receive Supplemental Security Income. If that's the case, you also qualify for Extra Help.

Proof that you have active South Carolina Department of Health and Human Services Healthy Connections (Medicaid) status that qualifies for Extra Help

- A copy of any state document or any printout from the state showing your active Medicaid status that qualifies for Extra Help. The active date shown has to be in the month of July or later of last year.

Proof of a Medicaid payment for a stay at a medical facility

Your stay at the medical facility must be at least one full month long, and must be in the month of July or later of last year.

- A billing statement from the facility showing the Medicaid payment
- A copy of any state document or any printout from the state system showing the Medicaid payment for you

If you first show one of the documents listed above as proof at the pharmacy, please also send us a copy. Mail the document to:

Humana

P.O. Box 14054

Lexington, KY 40512-4045

- 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.

I2. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for Medicare Part D drugs covered by our plan by spreading them across the calendar year (January- December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** I**f you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** "Extra Help" from Medicare is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit **www.Medicare.gov**.

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 a.m. to 7 p.m., 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. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at the phone number at the bottom of the page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also call 1-800-MEDICARE (1- 800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1- 877-486-2048.

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

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 if 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 this *Member Handbook.*

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A. Information about services and providers

Services are health care, supplies, behavioral health services, prescription and over-the- counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and behavioral health 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 and medical equipment.

Network providers are providers who work with our plan. These providers agree to accept our payment 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 nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers services covered by Medicare and Healthy Connections Medicaid. This includes behavioral health.

Our plan will generally pay for health care services and behavioral health services, 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 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 (go to **Section D1** for more information).
    - You don't need a referral 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 (go to **Section D1** for more information).
- **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:
    - If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I**).
    - If you need care that our plan covers and our network providers can't give it to you, you can get 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**.
    - If you need 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, you can get care from an out-of-network provider. 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.

C. Your care coordinator

C1. What a care coordinator is

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

To contact your care coordinator call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. This call is free.

C3. How you can change your care coordinator

If you want to change your care coordinator, call Member Services 1-866-432-0001 (TTY: 711). We're

available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time.

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 a PCP, and what a PCP does do 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. 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 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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 Medical Home

Your PCP will become your medical home. As a medical home, the PCP is your primary source for healthcare. They will refer you to a specialist if needed. They will also help manage your chronic conditions. You should have an ongoing, trusting relationship with your PCP. Your PCP knows your medical history. A medical home also includes the support team who works with your PCP to coordinate the services and care you need. The

goal is to help you be as healthy as possible. Your PCP will also help obtain prior authorization (PA) from us when needed.

Having a medical home is important because it is the first place you go to get the care you need to stay healthy. This is what having a medical home means.

- Your personal PCP gets to know you well
- Your PCP works with your other health care providers, such as specialists, including behavioral health providers and hospitals, to coordinate your care
- You get better health care because your PCP knows your health care needs
- You can better understand your illnesses and how to care for yourself
- You can understand how to get and take your medicine
- You only use the emergency room for health care emergencies
- The PCP may use other team members to help you get better care

Your choice of PCP

For information on choosing your PCP, call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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. 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 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time.

If you need a copy of the *Provider and Pharmacy Directory*, call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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. We will also let you know if any hospitals in your region stop accepting Humana Dual Integrated (HMO D-SNP).

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.

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,** of this *Member Handbook,* 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** in this *Member Handbook* for more information.)

D4. Out-of-network providers

Members are entitled to get services from out-of-network providers for emergencies, urgently needed services, and dialysis services for ESRD members. If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Authorization must be obtained from the plan prior to receiving care. In this situation, we will cover these services as if your provider were to be in our network.

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 Healthy Connections Medicaid.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Healthy Connections 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 services and supports (LTSS) help meet your daily needs for assistance and help improve the quality of your life. LTSS can help you with everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided in your home or in your community, but they could also be provided in a nursing home or hospital.

LTSS aren't covered by our plan, but might be available to you under Healthy Connections Medicaid. If you think you need LTSS, you can talk to your care coordinator about how to access them and whether you can join a Healthy Connections Medicaid waiver. Your care coordinator can give you information about how to

apply for an appropriate waiver and all of the resources available to you under the plan.

If you have questions, you can call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. The call is free.

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

Behavioral health services support mental health and substance abuse treatment needs you may have. This can include medication, counseling (therapy), social support and education.

This care may be given in a community setting, day program or a doctor's office, or in another place that's easier for you, like your home.

For behavioral health services, please call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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.

G. How to get self-directed care

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

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

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

G1. What self-directed care is

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

G2. Who can get self-directed care

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

G3. How to get help in employing personal care providers

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

H. 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.**
- If you need a ride to your health care visit or to plan-approved locations, call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. This call is free.

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 use 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 or its 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 follow up on your emergency care. You or your care coordinator should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Call Member Services 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. 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** of this *Member Handbook*.

The providers who give you 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 was not an emergency, we will 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 1-855-371-9234 (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 877-837-6952 (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 outside our 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.

Our plan covers worldwide emergency and urgent care services outside of the United States and its territories 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 get care you need 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 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

Don't pay directly for services that Healthy Connections Medicaid covers.

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** 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 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. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part 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 members 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're 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/coverage/clinical-research-studies**). 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. 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're against getting medical treatment that's "non-excepted."

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

In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.

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

M2. DME ownership if 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 (MA) integrated D-SNP plan like ours, 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 an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not 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 five years if medically necessary.

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

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new five-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 five 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. 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 Healthy Connections 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 the plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Member Services at 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. The call is free.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network 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 the services our plan pays for. (Drug coverage is in **Chapter 5**.) 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 Healthy Connections Medicaid covered services according to the rules set by Medicare and Healthy Connections Medicaid.
- The services (including medical care, behavioral health and substance use services, 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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Healthy Connections Medicaid coverage rules.
- For new members, 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 prior authorization. This means that you pay the provider in full for out-of-network services you get. **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.
- When you first join the plan, you can continue using the providers you use now for 90 days or until we have completed your comprehensive assessment and created a transition plan that you agree with. If you need to continue using your out-of-network providers after your first 90 days in our plan, we'll only cover that care if the provider enters a single case agreement with us. A single case agreement is an exception to treat the provider as an in-network provider. If you're getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact Member Services at 1-866-432-0001 (TTY: 711). We're available seven days a week, Oct 1 - March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time.

- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (*) or with a footnote. In addition, you must get PA for the following services not listed in the Benefits Chart:

  Diagnostic and Cardiac testing

  Breast cancer biopsy (excisional)

  Capsule Endoscopy

  Cardiac catheterization

  Computed Tomography

  EGD

  Electrophysiology (EPS) with or without mapping

  Loop recorder

  Molecular diagnostics/genetic testing

  MRI/MRA Magnetic resonance imaging and angiograms

  Myocardial perfusion imaging

  Nuclear stress test

  Outpatient transthoracic echocardiogram (TTE)

  Positron emission tomography (PET scan)/national oncology PET registry (NOPR)

  SPECT Single photon emission computed tomography

  Transesophageal echocardiogram (TEE)

  Pain Management

  Epidural steroid injections

  Facet injections

  Pain pump implants

  Spinal cord stimulators

  Spinal surgeries – spinal fusion, decompression, kyphoplasty and vertebroplasty

  Surgeries/procedures

  Abdominoplasty

  Ablation – Cardiac, bone, liver, kidney and prostate

  Arthroscopy – hip, knee and shoulder

  Blepharoplasty

Breast Procedures (Excludes breast reconstruction following medically necessary mastectomies for breast cancer)

Decompression of peripheral nerve (carpal tunnel)

Foot surgeries – bunionectomy and hammer toe

Lung biopsy and resection

Outpatient coronary arngioplasty/stent

Obesity Surgeries

Oral, Orthognathic, Otoplasty

Penile Implant

Peripheral revascularization (arthrectomy/angioplasty)

Surgery for Obstructive Sleep apnea

Surgical Nasal/Sinus Endoscopic Procedures and Balloon sinus ostial dilation endoscopies

Temporomandibular Joint (TMJ) Surgeries

Transcatheter Valve surgeries (TMVR/TAVR, TAVI and MitraClip)

Thyroid surgeries

Transplant Surgeries

Varicose Vein: Surgical Treatment and Sclerotherapy

Other services

Bone growth stimulators

Chemotherapy agents and supportive drugs and symptom management drugs

Chimeric antigen receptor-T cell therapy (Car-T)

Cochlear and auditory brainstem implants

Wearable cardiac devices

Transcranial magnetic stimulation (MH/SUD service)

Gastric Pacing

High Frequency Chest Compression Vests

Home Health/Home Infusion

Hyperbaric Therapy

Neuromuscular Stimulators

Noninvasive Home Ventilators

Orthotics/Prosthetics

Radiation therapy

- If our 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.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your Medicare & You 2027 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- If you lose your South Carolina Healthy Connections Medicaid eligibility but can be expected to regain it within six month(s), we'll continue to provide all Medicare benefits covered by Humana Dual Integrated (HMO D-SNP) H1396-001. When your South Carolina Healthy Connections Medicaid coverage ends, we won't pay for your South Carolina Healthy Connections Medicaid benefits.

We'll assist you to regain your South Carolina Healthy Connections Medicaid eligibility. If your South Carolina Healthy Connections Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your South Carolina Healthy Connections Medicaid benefits and your enrollment with us will continue. If you can't regain South Carolina Healthy Connections Medicaid within six month(s) we'll disenroll you from Humana Dual Integrated (HMO D-SNP) H1396-001. If you regain South Carolina Healthy Connections Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Important Benefit Information for Members with Certain Chronic Conditions

This plan offers Special Supplemental Benefits for the Chronically Ill (SSBCI). To be eligible for SSBCI, you must meet **ALL** of the following requirements:

1. Be diagnosed with one or more of the Eligible Chronic Conditions listed below.
2. Have a high risk of hospitalization or other significant adverse health outcomes.
3. Require intensive care coordination.

To be eligible for SSBCI, you must have one of the following:

- Have a medical claim in the Humana system that includes a diagnosis for one or more of the Eligible Chronic Conditions. The medical claim must have a date of service on or after 1/1/2022.

  OR

- Indicate on a Health Risk Assessment (HRA) that you have been diagnosed with at least one of the Eligible Chronic Conditions. The HRA must be completed on or after 1/1/2022.

Once you have met the first requirement for SSBCI eligibility through one of the above methods, we will review your member file and determine whether you meet the second and third requirements to be eligible to receive additional benefits through the Humana Healthy Options Allowance®.

You may contact Member Services for additional information and assistance.

Eligible Chronic Conditions for **Humana Healthy Options Allowance®**:

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

For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.

Contact us to find out exactly which benefits you may be eligible for.

SSBCI Disclaimer: The Humana Healthy Options Allowance* is a special supplemental benefit(s) for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may 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.

*If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.

Important Benefit Information for People Who Qualify for Uniformity Flexibility

If you are diagnosed with one or more of the health conditions identified below, you may be eligible for one or more Uniformity Flexibility supplemental benefits.

- Heart Failure (including HFrEF and non-HFrEF with qualifying additional conditions)
- Coronary Artery Disease (CAD)
- Hypertension
- Chronic Kidney Disease (CKD)
- Chronic respiratory conditions

You may be eligible for the following Uniformity Flexibility benefits if you meet the applicable criteria:

- Virtual Cardiac Recovery Program – for members with recent heart failure-related hospitalization

All preventive services are free. 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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	$0
Acupuncture for chronic low back pain We pay for up to 20 acupuncture visits 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) **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Acupuncture for chronic low back pain (continued) • Not associated with surgery; • 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 may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/ clinical nurse specialists (CNSs), 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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations. Your plan also allows services to be received by a provider licensed to perform acupuncture.	
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

Covered Service	What you pay
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 health or life. Ambulance services for other cases (non-emergent) must be approved by us. 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. *Prior authorization may be required	$0
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 **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
Autism Spectrum Disorder (ASD) Services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid coverage includes Allowable Evidence Based Practices (EBPs) and adaptive behavior treatment guidance. Services also include, but are not limited to, a cognitive behavioral intervention package, language training, and behavior identification assessments.	$0

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
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
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • coronary artery bypass surgery • stable angina pectoris (chest pain) • heart valve repair or replacement **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Cardiac (heart) rehabilitation services (continued) • coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
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 are eating well.	$0
Cardiovascular (heart) disease screening tests 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
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	$0

Covered Service	What you pay
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment Healthy Connections Medicaid covers 6 additional visits per year *Prior authorization may be required	$0
Clinical services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid pays for the following services provided in facilities that are not part of a hospital: • labs and x-rays • family planning services, including contraceptives • services provided by Developmental Evaluation Centers (DECs) • services provided by Ambulatory Surgical Centers (ASCs) • blood products and transfusions • dialysis • hospice services • coordination of care services	$0
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. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Colorectal cancer screening (continued) • 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 colonoscopy 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 three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • 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.	

Covered Service	What you pay
Communicable Disease Services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid pays for the following: • examinations • assessments • diagnostic procedures • health education and counseling • treatment • contact tracing, according to the Centers for Disease Control and Prevention (CDC) standards • specialized outreach services for tuberculosis (TB) cases All Members have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions.	$0
Dental services Certain dental services are available through the Healthy Connections Medicaid Dental Program. Humana Dual Integrated (HMO D-SNP) will pay for the following services: • emergency medical procedures performed by oral surgeons. • dental procedures related to the following: • organ transplants • oncology • radiation of the head and/or neck for cancer treatment • chemotherapy for cancer treatment • total joint replacement • heart valve replacement • trauma treatment performed in a hospital or ambulatory surgical center **This benefit is continued on the next page.**	$0 **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) 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 after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover **Mandatory Supplemental Dental Benefits** which include preventive and diagnostic services. *Prior authorization may be required	
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 and/or referrals.	$0
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 are 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

Covered Service	What you pay

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):
• Supplies to monitor your blood glucose, including the following:
  ○ a blood glucose monitor
  ○ blood glucose test strips
  ○ lancet devices and lancets
  ○ glucose-control solutions for checking the accuracy of test strips and monitors
• For people with diabetes who have severe diabetic foot disease, the plan will cover the following:
  ○ 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.
• For Continuous Glucose Monitors, see Durable medical equipment (DME) and related supplies.
The (preventive service) only applies to Diabetes self-management training.
	$0

Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems **This benefit is continued on the next page.**	$0 Your cost-sharing won't change after being enrolled for 36 months. Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months, you rent the equipment.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies • 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 • continuous glucose monitors (CGM)** • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Healthy Connections Medicaid also covers DME items such as sleep apnea monitors and devices and Augmentative Alternative Communication (AAC) devices. Other items may be covered. (for more information about this requirement, refer to **Chapter 4** of the *Medicare Managed Care Manual*): We pay for all medically necessary DME that Medicare and Medicaid usually pay for if our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. **Preferred Continuous Glucose Monitors (CGMs) are covered at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not covered through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically necessary. All CGMs will continue to be covered through durable medical equipment providers (DME). *Prior authorization may be required	For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After five years, you can choose to stay with the same company or go to another company. At this point, the five-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

Covered Service	What you pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, • 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** • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: o There isn't enough time to safely transfer you to another hospital before delivery. o 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. 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 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital in order for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.
Early and Periodic Screening, Diagnosis & Treatment (EPSDT) services (Healthy Connections Medicaid Covered) For members 20 years old and younger, EPSDT services include physical exams, laboratory tests, immunizations, and appropriate screenings.	$0

Covered Service	What you pay
Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will cover 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) • 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 the plan's network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)* • treatment for AIDS and other HIV-related conditions • genetic testing* Healthy Connections Medicaid may cover sterilizations* *Prior authorization may be required for genetic testing, treatment for medical conditions of infertility, and sterilizations.	$0

Covered Service	What you pay
Health and wellness education programs These are 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
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. In addition, we cover **Mandatory Supplemental Hearing Benefits** which include a routine hearing exam and hearing aid coverage. Healthy Connections Medicaid also covers visits for a re-evaluation of your hearing, up to 6 times per year. *Prior authorization may be required	$0 **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.
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
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

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 eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies Healthy Connections Medicaid covers additional home health aide and therapy visits. *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. *Prior authorization may be required	$0

Covered Service	What you pay
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 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 When you're admitted to a hospice, you have the right to stay in our plan. **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 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. You pay nothing for these services. **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*. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Hospice care (continued) **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. For more information on room and board coverage, refer to **Section G3**.	
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
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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Read **Chapter 6, Section D** of this *Member Handbook*, to learn more.	$0

Covered Service	What you pay
Incontinence supplies (Healthy Connections Medicaid Covered) Healthy Connections Medicaid pays for the following services: • diapers or briefs • incontinence pads/liners • underpads • wipes Prior authorization may be required.	$0
Inpatient hospital care (continued) 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 • inpatient substance abuse services **This benefit is continued on the next page.**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Covered Service	What you pay
Inpatient hospital care (continued) • in some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, 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 whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for reasonable lodging and travel costs for you and one other person. • blood, including storage and administration. Coverage of whole blood and packed red cells starts only with the first pint of blood you need. • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet Medicare Hospital Benefits 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. *Prior authorization may be required	

Covered Service	What you pay
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital – The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital • The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan *Prior authorization may be required	$0
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: ○ an internal body organ (including contiguous tissue), **or** ○ the function of an inoperative or malfunctioning internal body organ. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy *Prior authorization may be required	
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. *Prior authorization may be required	$0

Covered Service	What you pay
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 one 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. 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
Maternity services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid pays for the following services: • hospital inpatient delivery • freestanding birthing center services • newborn hearing and metabolic screenings • 17-P injections to reduce the risk of preterm birth • Buprenorphine monotherapy • nurse midwife services • prenatal care including an initial obstetrical exam • Non-Invasive Prenatal Screenings (NIPS) • postpartum care • ultrasounds • syphilis screenings	$0

Covered Service	What you pay
Meals and lodging (Healthy Connections Medicaid Covered) Healthy Connections Medicaid covers meals and lodging for you and an escort when traveling out-of-state to obtain a covered service.	$0
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. 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 order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary Healthy Connections Medicaid also provides coverage for nutritional counseling services for chronic or acute conditions, including medical nutrition therapy and obesity management.	$0
Medicare Diabetes Prevention Program (MDPP) Our plan pays 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.	$0

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 are getting 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). In addition to medication costs, you may need additional scans and tests before and/or during treatment. Talk to your doctor about what scans and tests you may need as part of your treatment. • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B does not 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 cannot 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 **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Medicare Part B drugs (continued) • 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 • 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®, 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 takes 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 Medicare Part D drug benefit. **This benefit is continued on the next page.**	

Covered Service	What you pay
Medicare Part B drugs (continued) **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. *Prior authorization may be required	
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. Prior authorization is required.	$0
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
Outpatient diagnostic tests and therapeutic services and supplies 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 **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • 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 *Prior authorization may be required	
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 from the Medicare fact sheet *Medicare Hospital Benefits* available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf**	$0

Covered Service	What you pay
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some drugs that you can't give yourself *Prior authorization may be required	$0
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 (CSW) • a clinical nurse specialist (CNS) • a licensed 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 *Prior authorization may be required	$0

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. Healthy Connections Medicaid also covers an additional 105 hours for any combination of occupational, physical, and speech therapy visits. *Prior authorization may be required	$0
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program **This benefit is continued on the next page.**	$0
Outpatient substance use disorder services (continued) • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment	
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. *Prior authorization may be required	$0

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's 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 the care received in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. *Prior authorization may be required	$0
Pharmacy services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid covers pharmacy services such as sickle cell gene therapy, at-home COVID tests, and tobacco cessation medications.	$0
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: ○ physician's office ○ certified ambulatory surgical center ○ hospital outpatient department ○ any other location • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Physician/provider services, including doctor's office visits • some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at 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, regardless of your location • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • 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 five-ten minutes **if**: ○ you're not a new patient **and** ○ the check-in isn't related to an office visit in the past seven 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 seven days **and** ○ the evaluation doesn't lead to an office visit within 24-hours or the soonest available appointment **This benefit is continued on the next page.**	

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) • 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 Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL. *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 *Prior authorization may be required	$0
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 medicationincluding the fee for injecting the drug, if applicable. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0

Covered Service	What you pay
Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
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 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 in this chart for details. *Prior authorization may be required	$0
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

Covered Service	What you pay
Rehabilitative behavioral health services (Healthy Connections Medicaid Covered) Healthy Connections Medicaid coverage includes: • screenings and assessments • crisis management services • intensive in-home services • psychotherapy • medication management • community support services • Assertive Community Treatment (ACT) • medical services • alcohol and drug treatment services provided in a residential or day program setting • behavioral health residential treatment program services	$0
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. 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
Serious Mental Illness (SMI) services (Healthy Connections Mediaid Covered Healthy Connections Medicaid covers assessments for medical and behavioral health needs, a person-centered care plan, and liaison services to coordinate appropriate providers and supports.	$0

Covered Service	What you pay
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.	$0
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12.** You are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's 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 **This benefit is continued on the next page.**	A new benefit period will begin on day one when you first enroll in a Medicare Advantage plan, or when you have been discharged from skilled care in a skilled nursing facility for 60 consecutive days. $0

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • X-rays and other radiology services given by nursing facilities • appliances such as wheelchairs 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 *Prior authorization may be required	
Smartphone Services (Healthy Connections Medicaid Covered) Stay connected to your care team, health plan, and support network. This benefit gives you 1 free smartphone with monthly talk, texts, and data per household. This benefit is for members 18 and older who qualify for the Federal Lifeline program. Talk to Humana Member Services or visit Humana's website to learn more.	$0
Smoking and tobacco use cessation Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Smoking and tobacco use cessation (continued) We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).. Healthy Connections Medicaid also covers: • Both over-the-counter (OTC) and prescription nicotine replacement therapy.	
Special Supplemental Benefits for the Chronically Ill **Humana Healthy Options Allowance®** **Over-the-Counter (OTC)** **$295** monthly allowance automatically loaded on a limited-use prepaid debit card to use at participating retail locations to buy eligible products from these categories: • Cold, flu and allergy medicine • Tooth and dental care items • Stomach and digestion products • First aid items and medical supplies • Bladder control upplies • Hearing aids you can buy without a prescription • Pain relief medicine • Skin care items • Sleep aids • Products to help you stop smoking • Vitamins and dietary supplements, and more If you already have a Humana Spending Account Card from your current plan, please keep it as your allowance will be loaded to this card. New members will receive a card in the mail. Please turn on, or activate, your card as soon as you get it. Use this card to spend your allowance. • Your allowance is added to the card on the first day of each month. • If you do not use all your money, the leftover amount moves, or rolls over, to the next month. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill **Humana Healthy Options Allowance® (continued)** **Over-the-Counter (OTC)** • Any money left on the card will end at the end of the year. It may also end sooner if you leave this plan. • Our plan is not responsible if someone uses your allowance without permission because your card was lost or stolen. • Some limits and rules may apply. • Keep this card safe, just like you would with any debit card. • Keep the card even after you spend the money. More money may be added later if you stay in the plan. • Limitations and restrictions may apply. You can use the free MyHumana® mobile app to find stores or check your balance. The app is available in the App Store® and Google Play®. You can also visit MyHumana.com or look at 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 which are severe or disabling and have a medical claim with Humana with a date of service on or after 1/1/2025 reflecting such diagnosis, you may be eligible to receive additional benefits through the Humana Healthy Options Allowance. Claims are reviewed daily for qualifying diagnosis. In some cases, members may be able to qualify by taking a Health Risk Assessment (HRA) indicating a diagnosis of one or more eligible chronic conditions. Qualifying chronic conditions: • Autoimmune disorders • Cancer • Cardiovascular disorders **This benefit is continued on the next page.**	

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill **Humana Healthy Options Allowance® (continued)** • 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 hyperlipidemia • Chronic hypertension • Chronic kidney disease • Chronic lung disorders • Dementia • Diabetes mellitus • HIV/AIDS • 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.) • 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 benefit is continued on the next page.**	

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill **Humana Healthy Options Allowance® (continued)** This allowance may be used to pay for approved services if the service provider is able to process the payment, 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 Merchant participation is subject to change and does not guarantee acceptance of the spending account card. Some rent and utility companies may not accept this form of payment. ***This spending allowance is a special supplemental benefit for members with specific chronic conditions who require intensive care coordination and are at a high risk for hospitalization or other adverse health outcomes. Qualifying conditions may 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. See the plan's Member Handbook for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income. Contact your local HUD office with questions.	

Covered Service	What you pay
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) 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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques	$0
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • 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. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Urgently needed care (contiued) 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.	
Virtual Cardiac Recovery Program (Uniformity Flexibility Benefit) **Eligibility and Description** Eligible members must have had an inpatient or observation hospitalization within the past 30 days related to a heart failure diagnosis, based on plan-established ICD-10 coding criteria. Members must also meet one of the following: (a) heart failure with reduced ejection fraction (HFrEF) or (b) heart failure with at least one additional condition (hypertension with complications, pneumonia excluding tuberculosis, or respiratory signs and symptoms). Additional conditions must be active within the same lookback period. Where ejection fraction is not directly available, clinically validated proxy criteria are used. All eligible members receive the same access. **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Virtual Cardiac Recovery Program (Uniformity Flexibility Benefit) (continued) **Benefit Description** Program delivers coordinated care through supervised exercise, nutrition and medication follow-ups, and functional assessments via individualized care plans delivered through telehealth. Includes up to 36 sessions per episode following a qualifying hospitalization with a $0 copayment. May include remote monitoring, behavioral coaching, education, and provider visits. This benefit supplements, and does not replace, Medicare-covered cardiac rehabilitation. **Scope and Limitations** The plan covers the following: • Services must be medically necessary and related to the qualifying condition. • One episode per qualifying hospitalization; each hospitalization may trigger a new episode if criteria are met. • Prior authorization may be required based on eligibility confirmation and medical necessity. • Services must be provided by plan-approved vendors. **Coverage Determinations and Appeals** Requests are handled as Medicare Advantage organization determinations. Members may request coverage decisions and file appeals.	
Vision care 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: **This benefit is continued on the next page.**	$0 **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
Vision care (continued) • people with a family history of glaucoma • people with diabetes • African-Americans who are 50 and over • Hispanic Americans who are 65 and 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. Healthy Connections Medicaid also covers an additional eye exam and complete set of glasses for members up to 21 years of age.	
"Welcome to Medicare" Preventive Visit We cover 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 (or vaccines), **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

Mandatory Supplemental Dental Benefit DEN282

Coverage Description

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

Deductible	**$0**	
Annual Maximum	**$1,000**	
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 – 2 procedure codes 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 procedure code per calendar year		
Bitewing x-rays - D0270, D0272, D0273, D0274	0%	100%
Intraoral X-rays (inside the mouth)– Frequency/Limitations – 6 procedure codes 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 – 1 procedure code per tooth per surface every 2 calender years		
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 per calendar year		
Scaling – moderate or severe gingival inflammation - D4346	0%	100%

Description of Benefit	In-Network You Pay*	Out-of- Network You Pay
Scaling and Root Planing – Frequency/Limitations – 1 procedure code every per calendar year, per quadrant		
Periodontal scaling and root planing – D4341, D4342	0%	100%
Endodontic Services – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Root canal – D3310, D3320, D3330	0%	100%
Endodontic Retreatment – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Retreatment of previous root canal therapy – D3346, D3347, D3348	0%	100%
Crowns – Frequency/Limitations – 1 procedure code per tooth every 5 calendar years		
Crowns (not retainer crowns) – D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	0%	100%
Onlay – D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664	0%	100%
Complete Dentures – Frequency/Limitations – 1 upper and lower complete or 1 upper and lower immediate denture every 5 calendar years, including routine post delivery care		
Complete denture – maxillary (upper) or mandibular (lower) – D5110, D5120	0%	100%
Immediate denture – maxillary (upper) or mandibular (lower) – D5130, D5140	0%	100%
Removable Partial Dentures (including routine post-delivery care) – Frequency/Limitations – 1 upper and 1 lower partial denture every 5 calendar years		
Partial dentures – resin or metal, maxillary (upper) or mandibular (lower) – D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228	0%	100%
Partial denture – maxillary (upper) or mandibular (lower)- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5228	0%	100%
Removable unilateral partial denture – maxillary or mandibular – D5282, D5283	0%	100%
Removable unilateral partial denture per quadrant - D5284, D5286	0%	100%
Extractions – Frequency/Limitations – 1 procedure code per tooth per lifetime		
Extraction, erupted tooth – D7140, D7210	0%	100%
Removal of impacted tooth-D7220, D7230, D7240	0%	100%
Removal of residual tooth roots- D7250	0%	100%
Oral Surgery – Frequency/Limitations – 2 procedure codes per calendar year		



Description of Benefit	In-Network You Pay*	Out-of- Network You Pay
Oral surgery – D7284, D7285, D7286, D7287, D7288, D7310, D7311, D7320, D7321, D7450, D7451, D7509, D7510, D7961, D7962, D7963	0%	100%
Denture Adjustments (not covered if within six months of initial placement) – Frequency/Limitations – 2 procedure codes per calendar year		
Complete denture adjustment– maxillary (upper) or mandibular (lower) – D5410, D5411	0%	100%
Partial denture adjustment – maxillary (upper) or mandibular (lower) – D5421, D5422	0%	100%
Denture Reline (not allowed on spare dentures or if within six months of initial placement) – Frequency/ Limitations – 1 upper procedure code and 1 lower procedure code per calendar year		
Reline complete denture – maxillary (upper) or mandibular (lower) – D5730, D5731, D5750, D5751	0%	100%
Reline partial denture – maxillary (upper) or mandibular (lower) – D5740, D741, D5760, D5761	0%	100%
Denture Repairs Base and Framework (not covered if within six months of initial placement) – Frequency/Limitations – 1 upper procedure code and 1 lower procedure code per calendar year		
Repair complete denture base – maxillary (upper) or mandibular (lower) – D5511, D5512	0%	100%
Repair partial denture base – maxillary (upper) or mandibular (lower) – D5611, D5612	0%	100%
Repair partial denture framework – maxillary (upper) or mandibular (lower) – D5621, D5622	0%	100%
Denture Repairs – Broken Teeth (not covered if within six months of initial placement) – Frequency/ Limitations – 2 procedure codes per tooth per calendar year		
Replace missing or broken tooth – D5520, D5630, D5640, D5650	0%	100%
Denture Repairs – Additions (not covered if within six months of initial placement) – Frequency/ Limitations – 1 procedure code per tooth per calendar year		
Add tooth or clasp to partial denture – D5660	0%	100%
Replace all teeth/acrylic – maxillary (upper) or mandibular (lower) – D5670, D5671	0%	100%
Denture Rebase (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		
Rebase complete denture – maxillary (upper) or mandibular (lower) – D5710, D5711	0%	100%
Rebase partial denture – maxillary (upper) or mandibular (lower) – D5720, D5721	0%	100%
Rebase hybrid prosthesis – D5725	0%	100%
Tissue Conditioning (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code per calendar year		



Description of Benefit	In-Network You Pay*	Out-of- Network You Pay
Tissue conditioning – maxillary (upper) or mandibular (lower) – D5850, D5851	0%	100%
Occlusal Adjustments (not covered if within six months of initial placement) – Frequency/Limitations – 1 procedure code every 3 calendar years		
Occlusal adjustment – limited – D9951	0%	100%
Pain Management – Frequency/Limitations – 1 procedure code per calendar year		
Palliative treatment of dental pain– D9110	0%	100%
Anesthesia Incremental– Frequency/Limitations – As needed with covered codes per calendar year (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)		
Administration of deep sedation/general anesthesia – D9222	0%	100%
Administration of moderate (conscious) sedation/intravenoys – D9239	0%	100%
Administration of moderate (conscious) sedation – non-intravenous parenteral – D9246	0%	100%
Anesthesia – General – Frequency/Limitations – 2 procedure codes per calendar year (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)		
Administration of deep sedation/general anesthesia – D9223	0%	100%
Administration of moderate sedation – intravenous – D9243	0%	100%
Administration of moderate sedation – non-intravenous parenteral – D9247	0%	100%
Anesthesia – Nitrous Oxide/Analgesia – Frequency/Limitations – 1 unit per visit – only covered if primary procedure is covered (in conjunction with extensive and/or complex procedures, subject to plan limitations and exclusions, subject to clinical review)		
Administration of nitrous oxide	0%	100%
Recementation of Crown – Frequency/Limitations – 1 procedure code every 5 calendar years		
Recement inlay, onlay or partial coverage restoration - D2910	0%	100%
Recement indirectly fabricated or prefabricated post and core – D2915	0%	100%
Recement crown – D2920	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. Information regarding each plan is available at **Humana.com/sb**.

*In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for

charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies).

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator for our nationwide network can be found at **Humana.com/FindCare**.

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 HER101

To use your benefit, you must call NationsHearing at 1-888-742-8201 to schedule an appointment.

Description of Benefit	In-Network You Pay*

• Routine Hearing Exam (1 per year)
• Up to 2 prescription hearing aids every year (1 per ear per year). Benefit is limited to the NationsHearing Level 2 prescription hearing aids, which come in various brands and options.
• Select Level 2 prescription hearing aids are available in rechargeable style options.
• **You must see a NationsHearing provider to use this benefit. Call 1-888-742-8201 to schedule an appointment (TTY: 711).**
• In-network hearing aid purchase includes:
  ○ 1 fitting appointment during first year following a hearing aid purchase with the original provider
  ○ 3 follow-up provider visits during first year following hearing aid purchase with the original provider
  ○ 60-day trial period
  ○ 3-year extended warranty
  ○ 3 years of batteries per non-rechargeable aid (up to 60 cells per ear per year)
• Benefit does not include or cover any of the following:
  ○ OTC hearing aids
  ○ Hearing aid accessories
  ○ Additional provider visits
  ○ Additional batteries (or batteries when a rechargeable hearing aid is purchased)
  ○ Costs associated with loss & damage warranty claims
	$0 Routine hearing exams
	$0 per Level 2 Aid

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

Mandatory Supplemental Benefit VIS780

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 • **$300** 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 **$300**

*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 or Medicare-covered vision can be found at **Humana.com/FindCare**.

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.

If you're out of the plan's service area for more than six months at a time but don't permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program that allows you to stay enrolled in our plan when you're outside of our service area but within the United States for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices.

Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you're in a visitor/traveler area, you can stay enrolled in the plan until 12/31/2027. If you don't return to our plan's service area by 12/31/2027, we'll end your membership in our plan.

F. Benefits covered outside of our plan

We don't cover the following services, but they're available through Healthy Connections Medicaid.

F1. Dental services

Diagnostics (oral evaluation and x-rays), preventive care (annual cleaning), restorative care (fillings), and surgical care extractions/removals) are covered on a fee-for-service basis. Please contact your care coordinator for more information.

F2. Non-emergency medical transportation

Transportation assistance is available to and from any medical appointment with a $0 copay. The type of assistance will depend on the member's medical situation. Requests for urgent or same day requests (such as transportation assistance for routine hospital discharges) will be verified with health care providers to confirm that the short timing is medically necessary. **Any member needing emergency transportation should call 911.**

- For more information, please contact your care coordinator or refer to the member brochure located at the website of ModivCare, which is the transportation broker: **www.mymodivcare.com/wp-content/uploads/2025/06/South-Carolina-Modivcare-Facility-Brochure.pdf**. If you have additional questions, please contact ModivCare using the contact information for your region in the member brochure.

F3. Hospice Room and Board

Hospice Room and Board services are "carved out" of Healthy Connections Medicaid Managed Care, which means the hospice provider will bill Medicaid directly on a fee-for-service basis. Room and board for hospice members residing in a nursing facility must be billed by the nursing facility (not the hospice provider) to Healthy Connections Medicaid.

F4. Home and Community-Based (HCBS) Waiver Services

Members who meet Nursing Home Level of Care but can remain safely at home with assistance may participate in one of three Home and Community-Based Waiver programs (Community Choices, HIV/AIDs, Mechanical Ventilator Dependent). These services are 'carved out' of Healthy Connections Managed Care, which means the HCBS provider will bill Medicaid directly on a fee-for-service basis.

To enroll in Healthy Connections HCBS program, a referral to Centralized intake is required.

DHHS/CLTC Centralized Intake: 888-971-1637

For electronic referrals: **phoenix.scdhhs.gov/cltc_referrals/new**

Under the Healthy Connections Medicaid HCBS program, the following services are covered under each HCBS waiver:

Community Choices Waiver

- Case Management
- Personal Care I/II
- Attendant Care
- Companion Care
- Home Delivered Meals
- Nutritional Supplements
- Adult Day Health Care
- Adult Day Health Care Transportation
- Adult Day Health Care Nursing
- Respite Care
- Personal Emergency Response System
- Tele-monitoring
- Pest Control
- Home Accessibility Adaptations
- Residential Personal Care II
- Specialized Medical Equipment & Supplies

HIV/AIDs Waiver

- Specialized Medical Equipment & Supplies
- Case Management
- Personal Care I/II
- Attendant Care
- Companion
- Home Delivered Meals
- Nutritional Supplements
- Pest Control

- Private Duty Nursing
- Home Accessibility Adaptations
- Specialized medical Equipment & Supplies

Mechanical Ventilator Dependent Waiver

- Case Management
- Personal Care I/II
- Attendant Care
- Private Duty Nursing
- Specialized Medical Equipment & Supplies
- Respite Care
- Personal Emergency Response System
- Home Accessibility Adaptations
- Pest Control
- Home Delivered Meals
- Nutritional Supplements

F5. 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.

Nursing Facility services are "carved out" of Healthy Connections Medicaid Managed Care, which means the Nursing Facility provider will bill Medicaid directly on a fee-for-service basis. Nursing Facility services for members residing in a nursing facility must be billed by the nursing facility to Healthy Connections Medicaid.

Services that we pay for include, but aren't limited to, the following:

- semi-private 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
- dental services, including dentures
- vision benefits
- hearing exams
- chiropractic care
- podiatry services

You can get care from the following places if they accept fee-for-service 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

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

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Healthy Connections 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 specific conditions listed. Even if you get 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 medically necessary,” according to Medicare and Healthy Connections 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 are not generally accepted by the medical community
- surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it
- a private room in a hospital, except when it is medically necessary

- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or a television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, 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
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- 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 and non-prescription contraceptive supplies
- 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'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

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

- Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).
- Services received from an out-of-network dentist are not covered benefits.
- Initial placement or replacement of a prior denture that is unserviceable and cannot be made serviceable. Spare dentures are not covered.
- Dental reline may not be covered within six months of initial denture placement or on spare dentures.
- Dental adjustments may not be covered within six months of initial denture placement or on spare dentures.
- Expenses incurred while you qualify for any workers' compensation or occupational disease act or

law, whether or not you applied for coverage.

- Services that are:
  - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
  - Furnished by, or payable under, any plan or law through any government or any political subdivision – this does not include Medicare or Medicaid.
  - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Any expense arising from the completion of forms. • Your failure to keep an appointment with the dentist.
- Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you are covered under this policy. We consider the following cosmetic dentistry procedures to include, but are not limited to:
  - Facings on crowns or pontics – the portion of a fixed bridge between the abutments – posterior to the second bicuspid;
  - Any service to correct congenital malformation;
  - Any service performed primarily to improve appearance;
  - Characterizations and personalization of prosthetic devices; or
  - Any procedure to change the spacing and/or shape of the teeth;
- Charges for:
  - Any type of implant and all related services, including crowns or the prosthetic device attached to it;
  - Precision or semi-precision attachments;
  - Other customized attachments;
  - Temporary or interim dental services;
  - Additional charges related to material or equipment used in the delivery of dental care;
  - The removal of any implants unless a covered service.
- Any service related to:
  - Altering vertical dimension of teeth.
  - Restoration or maintenance of occlusion.

  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
  - Bite registration or bite analysis.
- Infection control, including but not limited to sterilization techniques.
- Fees for treatment performed by someone other than a dentist, except for scaling, teeth cleaning and the topical application of fluoride, which can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision of the dentist in accordance with generally accepted dental standards.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service not specifically listed in the Coverage Information.
- Any service that is not eligible for benefits based upon clinical review; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Orthodontic services.
- Retainer Crown services when bridge coverage is not included in the benefit.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the reimbursement limit for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Local anesthetics, irrigation, bases, pulp caps, temporary dental services, study models/diagnostic casts, treatment plans, occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
- Any test, intraoperative, x-rays, laboratory, removal of existing posts, filling material, Thermafill carriers, and any other follow-up care is considered integral to root canal therapy. A separate fee for these services is not considered a covered expense.
- Repair and replacement of orthodontic appliances.
- Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
- The oral surgery benefits under this plan do not include:
  - Any services for orthognathic surgery;

  - Any services for destruction of lesions by any method;
  - Any services for tooth transplantation;
  - Any services for removal of a foreign body from the oral tissue or bone;
  - Any services for reconstruction of surgical, traumatic, or congenital defects of the facial bones;
  - Any separate fees for pre and post-operative care.
- General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periradicular surgical procedures for covered services.
- General anesthesia or conscious sedation administered due, but not limited to, the following reasons are not covered:
  - Pain control unless a documented allergy to local anesthetic is provided;
  - Anxiety;
  - Fear of pain;
  - Pain management;
  - Emotional inability to undergo surgery.
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning. • Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance.
- Any caries susceptibility testing, laboratory tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
- Separate fees for pre- and post-operative care and re-evaluation within 12 months are not considered covered services under the surgical periodontic services in this plan.
- We do not cover services that generally are considered to be medical services except those specifically noted as covered in the Coverage Information.
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.

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

- 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 including state or federal taxes which must be paid in full by the insured person to the provider.
- Orthoptic or vision training.
- Subnormal vision aids and associated testing.
- Aniseikonic lenses.
- Athletic or industrial lenses.
- Prisms (not covered with allowance, but may be available at a discounted rate off retail price; check with provider for details)
- Any service we consider cosmetic.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the allowance for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Plano lenses.
- Medical or surgical treatment of eye, eyes or supporting structures.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plans providing vision care.
- Corrective vision treatment of an experimental nature.
- Solutions and/or cleaning products for glasses or contact lenses.
- Non-prescription items.
- Costs associated with securing materials.

- Pre and post-operative services.
- Orthokeratology.
- Routine maintenance of materials.
- Artistically painted lenses.
- Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
    - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
    - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Your failure to keep an appointment.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Replacement of lenses or eyeglass frames furnished under this supplemental benefit that are lost or broken, unless otherwise available under the supplemental benefit.
- Any examination or material required by an employer as a condition of employment or safety eyewear.
- Pathological treatment.
- Copayments, coinsurances, and deductibles paid for supplemental benefits do not count toward your maximum out-of-pocket amount.
- These benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

Genetic/ Molecular Testing without successful completion of a Molecular Diagnostic Services Program (MolDX®) Technical Assessment

- Genetic/ Molecular Tests analyze things like DNA, RNA, proteins, or other biological markers in the body. If your doctor talks to you about one of these tests, make sure you understand whether it is covered by your plan. Genetic/ molecular tests that are not FDA approved must be evaluated and

approved with a technical assessment (TA) by Palmetto GBA as part of the MolDX program, to be covered by Humana and the Centers for Medicare and Medicaid Services (CMS).

- CMS requires that the TA must demonstrate the test's clinical utility in that it improves patient outcomes or changes physician management decisions and is also a valid test with proven clinical validity, and analytical validity.
- Only genetic/molecular testing that have a successfully completed TA will be considered for coverage. A complete list is available on the DEX® Diagnostics Exchange Registry.
- You can learn more about the medical necessity requirements of coverable genetic/ molecular testing at CMS.gov and Humana.com/coveragepolicies.
- Please confirm with your provider if the genetic/molecular testing in question is on the DEX® Diagnostics Exchange Registry.

Chapter 5: Getting your outpatient drugs

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 Healthy Connections 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 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 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** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that 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 will 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, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator. Some network pharmacies provide preferred cost-sharing, which may be lower than the cost-sharing at a pharmacy that offers standard cost-sharing. The Provider and Pharmacy Directory will tell you which network pharmacies offer preferred cost-sharing.

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 bills 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 Member Services or your care coordinator.

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 your 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.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call Member Services at 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time. The call is free.

Most prescriptions will ship within 3-5 days once the mail order pharmacy receives a valid prescription from your provider.. 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

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by contacting Member Services.
- If you get a prescription automatically by mail that you don't want, and you weren't contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

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 14 business days before your current prescription will run out.

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 you're billed and 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 14 calendar days before your current prescription will run out.

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 business days before your current prescription will run out to make sure your next order is shipped to you in time.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. You can call Member Services at 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time. The call is free.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs 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. 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 *or* 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 our 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 your prescriptions filled as a member of our plan. In these cases, please check with your care coordinator or Member Services first 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 instead of a copay 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 you pay for the drug at the out-of-network pharmacy and the cost we would 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 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 Healthy Connections 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 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 our *Drug List* or to ask for a copy of the list.
- Use our "Real-Time Benefit Tool" at **Humana.com** 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 Member Services at 1-866-432-0001 (TTY: 711)

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 Healthy Connections

Medicaid drugs) can't pay for a drug that Medicare Part A or Medicare 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 Healthy Connections 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 the treatment of anorexia or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them.

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of 5 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 our 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 to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking 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 version is available**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product 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 respectively 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 told us the medical reason that the generic drug or interchangeable biosimilar 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/PAL** 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/PAL** 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 our *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 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 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:
    - 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 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're 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've been in our 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 very personalized drug program
    - To ask for a temporary supply of a drug, call Member Services at 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local 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, 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 may 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 on 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.

D3. Asking for an exception

If a drug you take will be taken off our *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 for 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 Member Services or your care coordinator.

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 authorization 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 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 we 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.

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. If you are notified, contact your prescribing doctor.

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 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 or 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 above 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. You won'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.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this *Member Handbook.*

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's 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, 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 you 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 take 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 of 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 who 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 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 opioid and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your 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, the 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 you appeal, we'll 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 these 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 Healthy Connections 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 Healthy Connections Medicaid.

Because you're eligible for Healthy Connections 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 copay 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 our 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 our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* for 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 got 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 our 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 (EOB). We call it the *EOB* for short. The *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. 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 we 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 applicable, 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*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Healthy Connections Medicaid. These drugs are included in the *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 cost 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 our share of the cost of a drug, refer to **Chapter 7** of this *Member Handbook*.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, 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 *EOB* 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?

B1. 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.

B2. What about possible fraud?

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

If you think something is wrong or missing, or if you have any questions, call 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 your level of Extra help and which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic 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.	During this stage, we pay all of the costs of your drugs through December 31, 2027. You begin this stage when you've paid a certain amount of out-of-pocket costs.

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 *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 cost share for this plan. The copay is **$0**
- Cost-Sharing Tier 2 - Generic: Generic or brand drugs that our plan offers at a higher cost to you than Tier 1 Preferred Generic drugs. The copay is **$0**
- Cost-Sharing Tier 3 - Preferred Brand: Generic or brand drugs that our plan offers at a lower cost to you than Tier 4 Non-Preferred Drug drugs. The copay is $0-$14.40, depending on your income.
- Cost-Sharing Tier 4 - Non-Preferred Drug: Generic or brand drugs that our plan offers at a higher cost to you than Tier 3 Preferred Brand drugs. The copay is $0-$14.40, depending on your income.
- Cost-Sharing Tier 5 - Specialty Tier: Some injectables and other high-cost drugs. The copay is $0-$14.40, 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.

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

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 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	$0 copay	$0 copay
Cost-sharing Tier 2 Generic	$0 copay	$0 copay	$0 copay	$0 copay
Cost-sharing Tier 3 Preferred Brand	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40
Cost-sharing Tier 4 Non-Preferred Drug	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40

	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 5 Specialty Tier	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40	Copays for drugs may vary based on the level of Extra Help you get. For generic or brand drugs treated like generics: $0, $1.65, or $5.80 For brand drugs: $0, $5, or $14.40

*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. **A long term supply is not available for drugs in Tier 5.**

The drug costs shown are for members who qualify for Medicare's Extra Help program. If you no longer receive Extra Help, you may pay more for your prescriptions. You will receive a letter with your new drug costs.

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 $2,400. 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 $2,400 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 $2,400 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 seven days' supply of the drug, your payment is less than $.05 per day multiplied by seven 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 so you can 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 our 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 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 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 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 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 a copay for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay our share of 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

Our network providers must bill the plan for your covered 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. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of 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 more than your share of the cost, 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 Healthy Connections Medicaid we can't pay you back, but the provider will. Member Services or your care coordinator and/or ombudsperson, 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 Member Services or your care coordinator if you have any questions. If you don't know what you should've paid, or 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 include:

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 Member Services** or your care coordinator 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.

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.
   - 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 would pay at an in-network pharmacy.

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

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

   - If the pharmacy can't get the information right away, you may have to pay the full 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 Medicare Part D 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 of 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 made for Medicare services or call us. 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 365 days for Part C (Medical and Dental Services) and 36 months for Part D (Prescription drug) of the date you received the service, item, or drug. You must send your information to us within 365 days of the date you received the Healthy Connections Medicaid covered service, item, or drug.

To make sure you give 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 the form on our website **Humana.com/member/documents-and-forms**, 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 Claims
PO Box 14601
Lexington, KY 40512-4601
-OR-
Fax to 888-599-2730

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 already paid for the service or drug, we'll mail you a check for what you paid **or** 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 for our share of the cost of the 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**.

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 health care 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 incapacity, 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 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 including Spanish and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services 1-866-432-

0001 (TTY: 711) or write to Humana Dual Integrated (HMO D-SNP) at P.O. Box 14359 Lexington, KY 40512-4359. Member Service is available seven days a week, Oct. 1- March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time.

- Spanish materials are available upon request. You can make a standing request to get materials, now and in the future, in a language other than English. We will keep your preferred language other than English and/or alternate format for future mailings and communications. You will not need to make a separate request each time.
- You have a right to be treated with respect, dignity, and have a right to privacy.

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.
- Healthy Connections Medicaid at (888) 549-0820, 8 a.m. to 6 p.m., Monday – Friday, Eastern time.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

A. Su derecho a obtener 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 asequible, incluidos para aquellos con dominio limitado del inglés, habilidades limitadas de lectura, incapacidad auditiva, o aquellos con diversos antecedentes culturales y étnicos. También debemos informarle sobre los beneficios de nuestro plan y sus derechos de una manera que usted pueda entender. Debemos informarle sobre sus derechos cada año que esté en nuestro plan.

- Para obtener información de una manera que pueda entender, llame a Servicios para Afiliados. El plan cuenta con servicios de interpretación gratuitos disponibles para responder preguntas en distintos idiomas. Nuestro plan también puede proporcionarle materiales en otros idiomas que no sean el inglés, incluido el español, y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Afiliados al 1-866-432-0001 (TTY: 711) o escriba a Humana Dual Integrated (HMO D-SNP) en P.O. Box 14601, Lexington, KY 40512-4601. El Servicio para Afiliados está disponible los 7 días de la semana, del 1 de octubre al 31 de marzo y de lunes a viernes del 1 de abril al 30 de septiembre, de 8 a.m. a 8 p.m., hora local.
- Los materiales en español están disponibles a pedido. Puede hacer una solicitud permanente para obtener materiales, ahora y en el futuro, en un idioma distinto del inglés. Mantendremos su idioma preferido distinto del inglés y/o el formato alternativo para futuros envíos y comunicaciones. No tendrá que realizar una solicitud independiente cada vez.

Si tiene problemas para obtener información del plan debido a problemas de idiomas o discapacidad y desea presentar una reclamación, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- Healthy Connections de Medicaid al (855) 882-3901, de 8 a.m. a 6 p.m., de lunes a viernes, hora del este.
- 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 your care coordinator or Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- We **don't** require you to get referrals.
- 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 authorization (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 use 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 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 checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare and Healthy Connections Medicaid your PHI including information about your Medicare Part D drugs. If Medicare and/or Healthy Connections Medicaid releases your PHI for research or other uses, they do it according to federal laws.

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.
- 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.

Insurance ACE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at **https://huma.na/insuranceace**.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?

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

How do we collect information about you?

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

What information do we receive about you?

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

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including::

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.

- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restrictions on use and disclosure for specific types of information:

- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder ("SUD") subject to 42 CFR Part 2 ("Part 2") records; Biometric Information; Child or Adult Abuse or Neglect including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases
- If we receive SUD Part 2 records, we will not use or disclose such records, or provide testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceeding against you unless such disclosure is based on your written consent (separate from your consent for any other use or disclosure), or a court order after notice and an opportunity to be heard is provided to you, as provided by Part 2. A court order authorizing the use or disclosure of SUD Part 2 Records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your

written permission. You may cancel your permission at any time by notifying us in writing..

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes and SUD counseling notes
- Marketing purposes
- Sale of personal and health information
- Medical information that is disclosed pursuant to this Notice to an entity that is not a HIPAA-covered entity or business associate, may be subject to disclosure by the recipient and may no longer be

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner.

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not

required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

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

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

If you believe that your privacy has been violated, you may file a complaint with us by calling us at **866-861-2762** any time. You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

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

Our Responsibilities

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

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 866-861-2762
- Accessing our website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:

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

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 plan. To get an interpreter, call Member Services. This is a free call to you. To get materials in languages other than English including Spanish, please call Member Services 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct. 1- March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time. This is a free service to you. We can also give you information in large print, braille, or audio. To get materials in formats such as large print, braille, or audio, please call Member Services 1-866-432-0001 (TTY: 711). Member Service is available seven days a week, Oct. 1- March 31 and Monday - Friday, April 1 - Sept. 30, 8 a.m. - 8 p.m., local time.

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 our 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 our 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 **Chapters 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 Healthy Connections 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. We 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.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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

Sometimes people can't 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 can't make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you can't make decisions for yourself, including care you **don't** want.

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

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 the 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 form.
- **Fill 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 or your authorized representative can make a complaint with your care coordinator.

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

Chapter 9 of this *Member Handbook* tells you 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 I-CARE program at 1-800-868-9095. For more details about I-CARE, refer to **Chapter 2.**
- The Ombudsperson Program at 1-844-477-4632, TTY: 711, Monday through Friday, 8 a.m. to 6 p.m. Eastern time. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Medicare at 1-800-MEDICARE (1-800-633-4227). 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/publications/11534-medicare-rights-and-protections.pdf.**)

You can also visit the Healthy Connections Medicaid program website at **www.scdhhs.gov/resources/health-managed-care-plans/dual-special-needs-plans**.

We do not reward providers or our own staff for denying coverage or services. We do not offer financial rewards to our staff that affects their decisions. We do not deny or limit the amount, length of time, or scope of the service only because of the diagnosis or type of illness or condition. Any financial incentives for decision makers do not encourage decisions that result in under use of services.

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 **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or 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're 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 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 provider offices.
- **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 drugs. This will be a copayment and/or coinsurance. **Chapter 6** tells 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 your care coordinator or 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 Healthy Connections Medicaid your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Healthy Connections 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 your care coordinator** or **Member Services for help if you have questions or concerns.** You may also call your care coordinator to discuss your participation in an initial health screen and/or comprehensive assessment.

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 our plan.
- You need a service, item, or medication that our 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.**

There's an ombudsman office for South Carolina. To contact them and for additional resources to address your concerns, refer to **Chapter 2** for more information.

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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 our plan

You can call our plan at 1-866-432-0001, (TTY: 711) to help deal with a problem or answer questions.

Help from the State Health Insurance Assistance Program (SHIP)

You can call the State Health Insurance Assistance Program (SHIP) 1-800-868-9095. You can also review their website at **www.shiphelp.org/ships/south-carolina/**. SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP isn't connected with us or with any insurance company or health plan. The SHIP has trained counselors in every state, and services are free. In South Carolina, the SHIP is known as I-CARE, which stands for Insurance Counseling Assistance and Referrals for Elders. The I-CARE phone number is 1 800-868-9095 and their website is **www.aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud**. TTY users should call 711.

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 Healthy Connections Medicaid

You can call Healthy Connections Medicaid directly for help with problems. Here are some ways to get help from Healthy Connections Medicaid:

- Call Healthy Connections Medicaid at 1-888-549-0820, from Monday to Friday from 8 a.m. to 6 p.m. TTY: 1-888-842-3620. The call is free.
- Visit the Healthy Connections Medicaid website (**www.scdhhs.gov**).

Getting help from other resources

You can get help from other resources such as:

- Protection & Advocacy for People with Disabilities (P&A) toll free at 1-866-275-7273. TTY: 1-866-232-4525.
- South Carolina Legal Services toll free at 1-888-346-5592.

C. Understanding Medicare and Healthy Connections Medicaid complaints and appeals in our plan

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

Sometimes Medicare and Healthy Connections Medicaid processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a Healthy Connections 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**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

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. We're making a coverage decision whenever we decide what is covered for you and how much we pay (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 Healthy Connections 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 Healthy Connections 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 Healthy Connections 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:

- **Member Services** at the numbers at the bottom of the page.
- The **State Health Insurance Assistance Program (SHIP),** known as I-CARE in South Carolina, for free help. The SHIP is an independent organization. It isn't connected with this plan. The phone number is 1-800-868-9095. TTY users should call 711.
- **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.

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.

If you need other help or information, please call the ombudsman at 1-844-477-4632. TTY users should call 711.

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: 866-432-0001, TTY: 711.

- Faxing: 888-889-9934 for expedited coverage decisions only.
- Writing: 14601 Lexington, KY 40512-4601

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 within:

- **Seven 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.**

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

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

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 related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your representative must contact us. Call us at 866-432-0001.

Ask for a standard appeal or a fast appeal in writing or by calling us at 866-432-0001, (TTY: 711).

- 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're 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 ten 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 we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.
- 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. The IRO will notify you in writing when it gets your appeal. 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 Healthy Connections Medicaid service or item, you can file a Level 2 appeal and request a "State Fair Hearing" with the state yourself as soon as the time is up. For more information about the Level 2 appeal process, refer to **Section F4**.
- **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 seven 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. The IRO will notify you in writing when it gets your appeal. 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 Healthy Connections Medicaid service or item, you can file a Level 2 appeal and request a "State Fair Hearing" with the state yourself as soon as the time is up. For more information about the Level 2 appeal process, refer to **Section F4**.

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 seven 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. The IRO will notify you in writing when it gets your appeal.
- If your problem is about coverage of a Healthy Connections 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, Healthy Connections 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 Healthy Connections 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 Healthy Connections 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** 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 Healthy Connections Medicaid, your benefits for that service continue if you submit a Level 2 Appeal within ten 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 seven 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."
    - 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** 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 Healthy Connections Medicaid

A Level 2 Appeal for services that Healthy Connections Medicaid usually covers is a Fair Hearing with the state. In South Carolina, a Fair Hearing is called State Fair Hearing. You must ask for a State 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.

You can ask for a State Fair Hearing by filing your request online at msp.scdhhs.gov/appeals.

You can also deliver your request in person, fax your request to 803-255-8206, or write to:

Division of Appeals and Hearings
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

If a hearing is granted, the Division of Appeals and Hearings will mail you a notice giving the time, date, and place of the hearing. During the hearing, an impartial hearing officer will listen to your explanation of why you don't agree with our action. The hearing officer will also listen to our explanation of the action taken. The hearing officer will ask questions to get enough information to decide if your case was handled correctly.

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 copay for Part D Covered Drugs.

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 the payment 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 F**. 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 Healthy Connections 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 Healthy Connections 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. For drugs covered only by Healthy Connections Medicaid follow the process in **Section E**.

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**".

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a "**tiering 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 Tier 3- Preferred Brand, Tier 4- Non-Preferred Drug, and Tier 5- Specialty Tier.
   - 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 866-432-0001, 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 866-432-0001, 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 seven 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 seven 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 seven 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 seven 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) 24 hours a day, 7 days a week. 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 South Carolina, the QIO is Acentra Health. Call them at 1-888-317-0751, TTY: 711. 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 (I-CARE) Insurance Counseling Assistance and Referrals for Elders at 800-868-9095, TTY: 711.

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 1-888-317-0751, TTY: 711 from 9 a.m. to 5 p.m. Monday through Friday and from 11 a.m. to 3 p.m. on Saturdays, Sundays, and holidays. You can also leave a message at any time.

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** 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 State Health Insurance Assistance Program (SHIP), known as I-CARE in South Carolina, at

1-800-868-9095. TTY users should call 711.

- **Contact the QIO.**
  - Refer to **Section H2** of this *Member Handbook*, 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. Call them at 1-888-317-0751, TTY: 711, from 9 a.m. to 5 p.m. Monday through Friday and from 11 a.m. to 3 p.m. on Saturdays, Sundays, and holidays. You can also leave a message at any time.

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.

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 Healthy Connections Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Healthy Connections Medicaid usually covers. The letter you get from the Division of Appeals and Hearings will tell you what to do if you want to continue the appeals process.

If you made a Level 1 Appeal and a Level 2 Appeal for Healthy Connections Medicaid services or items, and both of your appeals were turned down, you have the right to additional levels of appeal. If you have questions after your Level 2 Appeal, contact the ombudsman at 1-844-477-4632. TTY users should call 711. This advocate will explain your options and will always act in your best interest.

Level 3 of the appeals process is an Administrative Law Court (ALC) hearing. If you want an ALC hearing, start by completing the "Request for Contested Case Hearing" form available at **www.scalc.net/pub/pubRequestForContestedCaseHearing.pdf**. You must submit this form within 30 calendar days of the date you were notified of the Level 2 decision. There is a $25 fee to appeal. If you can't afford the fee, you can file a "Request to Waive Filing Fee." This form can be found at **www.scalc.net/pub/pubRequestToWaiveFilingFee.pdf**.

If you're appealing a Level 2 decision made by hearing, you'll be responsible for the cost of making a transcript of the hearing. A transcript is a written record of the hearing. The cost of the transcript is approximately $16 for each hour that the transcriptionist spends typing the transcript.

The rules for appealing to the ALC are found at **www.scalc.net/rules.aspx**. If you don't follow the rules, your appeal may be dismissed.

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.
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.

Complaint	Example
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've 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 866-432-0001 (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 866-432-0001. 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.

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.

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.

The Ombudsperson

You can call the ombudsperson to tell them about your complaint. They aren't connected with us or any insurance company or health plan. The phone number for the ombudsperson is 1-844-477-4632. TTY users should call 711. This call is free and so are the services.

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:

SC Department of Health & Human Services
Office of Civil Rights & Privacy
1801 Main Street PO Box 8206
Columbia, South Carolina 29202
Telephone number: 888-808-4238 TTY: 888-842-3620
Email: civilrights@scdhhs.gov

You may also have rights under the Americans with Disability Act (ADA) and under state law. You can contact SC Department of Health & Human Services Office of Civil Rights & Privacy at 888-808-4238, TTY: 888-842-3620.

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 South Carolina, the QIO is called Acentra Health. The phone number for Acentra Health is 1-888-317-0751. TTY users call 711.

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 Healthy Connections 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 also have Healthy Connections Medicaid, you can end your membership with our plan including any month of the year.

In addition, Medicare rules mean you may end or switch 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 Healthy Connections 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 leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, 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.
- South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670.
- The State Health Insurance Assistance Program (SHIP), I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711.

B. How to end your membership in our plan

If you decide to end your membership you can do so by 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 173.
- Call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. Tell them you want to leave Humana Dual Integrated (HMO D-SNP) and join a different plan. If you're not sure what plan you want to join, they can tell you about other plans in your area. **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Healthy Connections 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:	**Here is what to do:**
Another plan that provides your Medicare and most or all of your Healthy Connections 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.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to **www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members**. If you need help or more information: • After you contact Medicare about changing plans, Medicare will work with Healthy Connections Medicaid to make the change. For more information about this process, you can call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. • Call the SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. **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 drug plan**	**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 SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll continue to receive your applicable Medicaid services through the same company that offers your current plan.
3. You can change to: **Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason** **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 I-CARE at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711.	**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 SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll continue to receive your applicable Medicaid services through the same company that offers your current plan.

4. You can change to:	**Here is what to do:**
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**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to **www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members**. If you need help or more information: • Call the SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. You'll continue to receive your applicable Medicaid services through the same company that offers your current plan.

C2. Your Healthy Connections Medicaid services

If you leave our plan, you'll get your Healthy Connections Medicaid services through a different Healthy Connections Medicaid managed care plan run by our company. This is called an "aligned" health plan.

Your Healthy Connections Medicaid services will include services covered by the South Carolina state plan, including behavioral health care.

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 Healthy Connections 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're hospitalized on the day that your membership in Humana Dual Integrated (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new

health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Healthy Connections Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're 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, call Member Services to find out if where you're 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 drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
    - You must be a United States citizen or national, or an eligible non-citizen.
    - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

If you lose your South Carolina Healthy Connections Medicaid eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Humana Dual Integrated (HMO D-SNP) H1396-001. When your South Carolina Healthy Connections Medicaid coverage ends, we won't pay for your South Carolina Healthy Connections Medicaid benefits. However, during this period, we won't continue to cover Healthy Connections Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period.

We'll assist you to regain your South Carolina Healthy Connections Medicaid eligibility. If your South Carolina Healthy Connections Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your South Carolina Healthy Connections Medicaid benefits and your enrollment with us will continue. If you can't regain South Carolina Healthy Connections Medicaid within six months we'll disenroll you from Humana Dual Integrated (HMO D-SNP) H1396-001. If you regain South Carolina Healthy Connections Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Healthy Connections Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's 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 file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of 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 ending your membership, you can call Member Services at the number at 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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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 Healthy Connections 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. SC Department of Health & Human Services Office of Civil Rights & Privacy at 888-808-4238, TTY: 888-842-3620.
- 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 Healthy Connections 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 Healthy Connections Medicaid is the payer of last resort.

D. Patient confidentiality and notice about privacy practices

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

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Member Services at 866-432-0001 (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. 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.

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 866-432-0001 (TTY: 711) at any time. The call is free.
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com
- 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 866-432-0001 (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 this *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 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.

Behavioral health: An all-inclusive term referring to mental health and substance use disorders.

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."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent **$2,400** for Part D covered drugs during the year.

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.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we 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.

Here is 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 seven-day supply of the drug, your payment is less than $0.05 per day multiplied by seven days, for a total payment less than $0.35.

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 name, 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 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 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: 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".

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.

Healthy Connections Medicaid: This is the name of South Carolina's Medicaid program. Healthy Connections Medicaid is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and some drugs not covered by Medicare. Refer to **Chapter 2** for information about how to contact Healthy Connections Medicaid.

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 six 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 **don't** 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.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach **$2,400**. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

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.

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. Our health plan is an integrated D-SNP.

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.

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.

List of Covered Drugs (Drug List): A list of prescription 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"

Managed Care Organization: A health plan that serves members on a risk basis through a network of employed or affiliated providers.

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 MA 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 the services covered by Medicare Part A and Medicare 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 excludes 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 don't need to be in the hospital.

Ombudsman or Ombudsperson: 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 ombudsperson's services are free. You can find more information 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's 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.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care 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 protect, 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.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

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.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. 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.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

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 Healthy Connections Medicaid service that we won't approve, or we won't continue to pay for a Healthy Connections 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 over. 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 our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

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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)**.

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسِّيق البديل مجاناً. 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)** հեռախոսահամարով:

Bǎsóò [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fónɔ́-nyɔ,, kè nyɔ-ɓɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ.̌ Ɗá **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]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i 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 d’assistance linguistique, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 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] : મફત 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)**

हिंदी [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)**.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

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Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare 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。

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]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná’álwo’, bee haz’áanii, dóó naaltsoos t’áá ajiłii’ígíí bee ak’e’elyaaígíí t’áá jiik’eh hóló. **877-320-1235 (TTY: 711)** bich’į’ hodíílnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian 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]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை 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 miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó lọ́fẹ̀ẹ́. Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

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**.

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

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Humana Dual Integrated (HMO D-SNP) Member Services

CALL	866-432-0001 Calls to this number are free. Member Services is available seven days a week, Oct 1-March 31 and Monday - Friday, April 1 - Sept 30, 8 a.m. - 8 p.m, Local Time. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	P.O. Box 14601 Lexington, KY 40512-4601
WEBSITE	**Humana.com**