



## Group Medicare Employer Regional PPO

### EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of Humana Insurance Company or Humana Health Insurance Company of Florida, Inc. /Humana Group Medicare Employer Regional PPO.

This booklet gives the details about your Medicare health coverage and explains how to get health care you need. This booklet is an important legal document. Please keep it in a safe place.

### Humana Customer Service:

For help or information, please call Customer Service at the number on the back of your membership card. You can call seven days a week from 8 a.m. to 8 p.m. Calls to these numbers are free. You may also go to our Plan Website at [Humana.com](http://Humana.com).

Hours of Operation:

8 a.m. to 9 p.m., Monday - Friday  
Closed Saturday and Sunday

Our automated phone system may answer your call after 6 p.m. and on Saturdays, Sundays, and some public holidays. Just leave a message and select the reason for your call from the automated list. We'll call back by the end of the next business day. Please have your Humana ID card handy when you call.

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## **Section 1 - Introduction**

### **Contact Information**

#### **Telephone numbers and other information for reference**

#### **How to contact our Plan Customer Service**

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you.

Call Customer Service seven days a week, from 8 am to 8 pm. A customer service representative will be available to answer your call from 8 am until 8 pm. However, your call may be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call shortly.

**CALL** Customer Service at the number on the back of your membership card. Calls to these numbers are free.

**TTY** 1-800-833-3301. This number requires special telephone equipment. Calls to this number are free.

**WRITE** P.O.Box 14168  
Lexington, KY 40512-4168

**WEBSITE** **[Humana.com](http://Humana.com)**

## Contact Information for Grievances, Organization Determinations, Coverage Determinations and Appeals

### Part C Organization Determinations

**CALL** Customer Service at the number on the back of your membership card. For expedited "fast" organization determinations, call 1-866-737-5113. Calls to these numbers are free.

**TTY** 1-800-833-3301. This number requires special telephone equipment. Calls to this number are free. For expedited determinations call 1-800-877-8973.

**FAX** For expedited "fast" organization determinations, fax your request to: 1-843-736-2500.

**WRITE** Humana Correspondence., Humana Group PPO,  
P.O.Box 14168, Lexington, KY 40512-4168.

For information about Part C organization determinations, see Section 8.

### Part C Grievances

**CALL** Customer Service at the number on the back of your membership card. For expedited "fast" grievances, call 1-800-867-6601. Calls to these numbers are free.

**TTY** 1-800-833-3301. For expedited "fast" grievances, call 1-800-833-3301. This number requires special telephone equipment. Calls to these numbers are free.

**FAX** For expedited "fast" grievances, fax your request to:  
1-800-949-2961.

**WRITE** Humana Grievance and Appeal Dept., Humana Group PPO,  
P. O. Box 14165, Lexington, KY 40512-4165.

For information about Part C grievances, see section 7.

**Part C Appeals**

- CALL** 1-877-511-5000. For expedited "fast" appeals, call 1-800-867-6601. Calls to these numbers are free.
- TTY** 1-800-833-3301. For expedited "fast" appeals, call 1-800-833-3301. This number requires special telephone equipment. Calls to these numbers are free.
- FAX** For expedited "fast" appeals, fax your request to: 1-800-949-2961.
- WRITE** Humana Grievance and Appeal Dept., Humana Group PPO, P. O. Box 14165, Lexington, KY 40512-4165.

For information about Part C appeals, see Section 8.

**State Health Insurance Assistance Program (SHIP) - a state program that gives free local health insurance counseling to people with Medicare**

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time. Section 2 has more information about your Medigap guaranteed issue rights.

You can find contact information for the SHIP in your state or territory in the state specific data sheets at the end of the Evidence of Coverage. You can also find the Web site for your local SHIP at [www.medicare.gov](http://www.medicare.gov) on the Web.

**Quality Improvement Organization - a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare**

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 8 for more information about complaints, appeals and grievances.

You can find contact information for the QIO in your state or territory in the state specific data sheets at the end of the Evidence of Coverage.

**How to contact the Medicare program**

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit [www.medicare.gov](http://www.medicare.gov). This is the official government Website for Medicare information. This Website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

**Other organizations (including Social Security and Medicaid, a state government agency that handles health care programs for people with limited resources)**

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, refer to the state specific data sheets at the end of the Evidence of Coverage.

**Social Security**

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit [www.ssa.gov](http://www.ssa.gov) on the Web.

**Railroad Retirement Board**

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 1-312-751-4701. You may also visit [www.rrb.gov](http://www.rrb.gov) on the Web.

**"Group" Coverage**

Call the Group's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

**Welcome to Humana Group PPO!**

Humana Group PPO is a Preferred Provider Organization (PPO) plan.

Thank you for your membership in our Plan; you are getting your health care through our Plan. This plan is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this Evidence of Coverage, we refer to Humana Group PPO as "Plan" or "our Plan."

This Evidence of Coverage explains how to get your health care through our Plan.

This Evidence of Coverage, together with your riders (including optional supplemental benefit brochures), Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan.

You are still covered by Medicare, but you are getting your Medicare services as a member of our Plan.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need including some rules you must follow.
- What you will have to pay for your health care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave our Plan.

If you need this Evidence of Coverage in a different format (such as in Spanish, or large print), please call us so we can send you a copy.

## **Eligibility Requirements**

To be a member of our Plan, you must live in our service area, be enrolled in Medicare Part A, and Medicare Part B. If you currently pay a premium for Medicare Part A and Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

**Use your plan membership card, not your red, white, and blue Medicare card**

Now that you are a member of our Plan, you must use our membership card for services covered by this plan. While you are a member of our Plan and using our Plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services, items Section 3 for information on covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

**The Provider Directory gives you a list of plan providers**

Every year, as long as you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of our Plan providers. If you don't have the Provider Directory, you can get a copy from Customer Service. Contact information is located in Section 1 of this booklet. You may ask Customer Service for more information about our Plan providers, including their qualifications and experience.

Be sure to contact non-network doctors before you see them to make sure they accept Medicare assignment and have agreed to accept payment from Humana.

## How do I keep my membership record up to date?

We have a membership record about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use your membership record to know what services or drugs are covered for you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 6 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting PEIA know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell PEIA about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Customer Service at the number on the back of your id card.

## The geographic service area for our Plan.

If you live in the following market... Then your service area is:

Alabama.....	Alabama and Tennessee
Arizona.....	Arizona
Arkansas .....	Arkansas and Missouri
North Florida.....	North Florida
South Florida.....	South Florida
Georgia.....	Georgia and South Carolina
Illinois.....	Illinois and Wisconsin
Indiana.....	Indiana and Kentucky
Kansas.....	Kansas and Oklahoma
Kentucky.....	Indiana and Kentucky
Louisiana.....	Louisiana and Mississippi
Michigan.....	Michigan
Mississippi.....	Louisiana and Mississippi
Missouri.....	Arkansas and Missouri
North Carolina.....	North Carolina and Virginia
Ohio.....	Ohio
Oklahoma.....	Kansas and Oklahoma
Pennsylvania.....	Pennsylvania and West Virginia
South Carolina.....	Georgia and South Carolina
Tennessee.....	Alabama and Tennessee
Texas.....	Texas
Virginia.....	North Carolina and Virginia
West Virginia.....	Pennsylvania and West Virginia
Wisconsin.....	Illinois and Wisconsin

## **Section 2 - How You Get Care**

### **Providers you can use to get services covered by our Plan.**

While you are a member of our Plan you may use either providers who accept Medicare assignment as well as Humana's payment terms and conditions, or providers who accept Medicare assignment but do not accept Humana's payment terms and conditions. If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule. Refer to [Section 4](#) for more information.

### **What are "plan providers?"**

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services.

We call them "plan providers" when they participate in our Plan. When we say that plan providers "participate in our Plan," this means that we have arranged with them to coordinate or provide covered services to members in our Plan.

### **What are covered services?**

"Covered services" is the general term we use in this booklet to mean all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in [Section 3](#).

### **Rules about using providers to get your covered services .**

If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule. See [Section 3](#) for the costs when you get services from plan providers. Medicare requires that we have or arrange for enough providers to give you all medically necessary plan covered services. You don't need to get a referral or prior authorization when you get care for many services. However, before getting services from providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary. Refer to [Section 3](#) for more information. If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. Be sure to contact doctors before you see them to make sure they accept Medicare assignment and have agreed to accept payment from Humana.

## **How do you get care from doctors, specialists and hospitals?**

A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such doctors as:

- oncologists (who care for patients with cancer)
- cardiologists (who care for patients with heart conditions),
- orthopedists (who care for patients with certain bone, joint, or muscle conditions).

You do not need to get a referral or prior authorization when you get care from non-plan providers. However, before receiving services from non-plan providers you may want to confirm with your plan that the services you receive are covered by your plan and are medically necessary.

## **What if your doctor or other provider leaves your plan?**

If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule. If you have questions about your medical costs when you travel, please call Customer Service.

## **Getting care if you have a medical emergency or an urgent need for care**

### **What is a "medical emergency"?**

A "medical emergency" is when you reasonably believe that your health is in serious danger when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

## What should you do if you have a medical emergency?

### If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. **You don't need to get approval or a referral first from your primary care physician or other plan provider.**
- We request for you to notify Humana of your emergency so that we may guide you in any needed follow up. Please contact customer service listed in [Section 1](#).

We may help manage and follow up on your emergency care.

When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines.

## What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States.
- World-wide Coverage - under the plan, you have medical coverage while traveling outside the United States. You're responsible for a \$50 copayment.

**Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health.

## What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care - thinking that your health is in serious danger - and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" see earlier in this section). However, please note that:

- If you get any extra care after the doctor says it wasn't a medical emergency, the amount of cost-sharing that you pay will depend on whether the provider accepts Medicare assignment as well as Humana's payment terms and conditions.
- If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule.

**What is urgently needed care? (This is different from a medical emergency)**

Urgently needed care refers to a non-emergency situation where you are inside the United States, you need medical attention right away for an unforeseen illness, injury, or condition.

**What is the difference between a "medical emergency" and "urgently needed care"?**

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

**How to get urgently needed care?**

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider. The plan is obligated to cover all urgently needed care at the cost-sharing levels that apply to care received within the Plan network.

**NOTE:** If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined in other sections of this document.

**Hospital care, skilled nursing facility care, and other services****How do you get hospital care?**

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading "Inpatient Hospital Care". We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule. Refer to [Section 3](#) for more information.

Except in cases of medical emergencies, request prior authorization for your hospital stay. Your physician must call to authorize all admissions. Your Physician will let you know that prior authorization has been granted.

### **What happens if you join or leave our Plan during a hospital stay?**

If you either join or leave our Plan during an inpatient hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Service. Customer Service can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

### **What is skilled nursing facility care (SNF)?**

"Skilled nursing facility care" means a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

### **How do you get Skilled nursing facility care (SNF care)?**

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

**Are Nursing Home stays that provide custodial care covered?**

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. We don't cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

**What are the benefit period limitations on coverage of skilled nursing facility care?**

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A **"benefit period"** begins on the first day you are admitted as an inpatient at a Medicare-covered hospital or SNF. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in [Section 3](#).

**What are the situations when you may be able to get care in a Skilled Nursing Facility (SNF)?**

If you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost share based on Original Medicare's fee schedule. However, there are some instances where you may be at a SNF that doesn't accept Medicare assignment or Humana's payment terms and conditions that may be covered. These include, but aren't limited to, the following:

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

**What happens if our Plan didn't authorize your care?**

Except in cases of medical emergencies, your provider must obtain prior authorization for your SNF stay. Your physician will let you know that prior authorization has been granted.

## **What happens if you join or leave our Plan during a Skilled Nursing facility (SNF) stay?**

If you either join or leave our Plan during a SNF stay, please call Customer Service. Customer Service can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and weren't a plan member.

## **How do you get home health care?**

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 3 under the heading "Home health agency care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements are met.

## **When can home health care include services from a home health aide?**

As long as some qualifying skilled-nursing services are *also* included, the home health care you get can include services from a home health aide. A home health aide doesn't have a nursing license or provide therapy. The home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). The services from a home health aide must be part of the home care of plan for your illness or injury, and they aren't covered unless you are also getting a covered skilled nursing service. "Home health services" don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

## **What are "part-time" and "intermittent" home health care services?**

If you meet the requirements given above for getting covered home health services, you may be eligible for "part-time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "intermittent"** means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

## **What is hospice care?**

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients

who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

### **How do you get hospice care if you are terminally ill?**

As a member of our Plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Customer Service to get a list of the Medicare-certified hospice providers in your area.

### **How is your hospice care paid for?**

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified hospice, you will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. If a PPO member uses non-plan providers for non-hospice related care, the Plan provides coverage at the out-of-plan level.

### **How to get more information on hospice care:**

Visit [www.medicare.gov](http://www.medicare.gov) on the Web. Under "Search Tools," "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## **How to get an organ transplant if you need it:**

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). *All transplant services must receive prior authorization Call 1-866-421-5663 (TTY# 1-800-336-6709) Monday-Friday 8:30 a.m.-5 p.m .EST.* In order to be considered in network, the facility must be Medicare approved and part of the Humana Transplant Network (NTN). A transplant performed at a facility that is only Medicare approved would be considered out of network. The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved /NTN in order to be considered in network transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Note: If enrollees are sent outside of their community for a transplant, the plan must arrange or pay for appropriate lodging and transportation costs for the enrollee and a companion as well as ensuring post transplant continuity of care.

## **How can you participate in a clinical trial?**

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care that is unrelated to the clinical trial through our Plan.

You will have to pay the same coinsurance amounts charged under Original Medicare for services you received in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan. For instance, you will be responsible for Part B coinsurance - generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no coinsurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare coinsurance rules, called *Medicare & You*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the Web.

You don't need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know what services you will get from clinical trial providers and the cost for those services. You may view or download the publication "Medicare and Clinical Trials" At [www.medicare.gov](http://www.medicare.gov) on the Web. Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **How to access care in Religious Non-medical Health Care Institutions**

Care in a Medicare-certified **Religious Non-medical Health Care Institution** (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan.

## Section 3 - Covered Benefits

### Covered Services

#### What are "covered services?"

This section describes the medical benefits and coverage you get as a member of our Plan. **"Covered services" means the medical care, services, supplies, and equipment that are covered by our Plan.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. Section 6 tells about **services that aren't covered** (these are called "exclusions").

There are some conditions that apply in order to get covered services.

Some general requirements apply to all covered services.

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. See Section 11 for a definition of "medically necessary."

Services that Humana Group PPO Plan requests prior authorization for are noted in the benefits chart.

**Paying your share of the cost when you get covered services .**

The "deductible" is the amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services. Your annual deductible is \$25. Please refer to the following Benefits Chart for services that are excluded from your deductible.

**What is the maximum amount you will pay for covered services?**

There is a limit to how much you have to pay out-of-pocket for your covered health care services each year. Once the total costs for your covered health care services, including your copayments, reaches your out-of-pocket maximum, then you won't have to continue paying for these expenses for the remainder of the year.

Your annual out-of-pocket maximum is \$750. Please refer to the following Benefits Chart for services that are excluded from your out-of-pocket maximum.

Benefits chart - your covered services	What you must pay when you get these covered services
<b>Inpatient Services</b>	
<p><b>Inpatient hospital care</b> For more information about inpatient hospital care, see <a href="#">Section 2</a>.</p>	<p><u>In Network</u> \$100 copayment per admission</p>
<p>You are covered for unlimited number of days for medically necessary services. Covered services include, but aren't limited to, the following:</p>	<p>You pay nothing for physician services at a hospital.</p> <p>Humana Group PPO Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 1-800-833-3301).</p>
<ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary).</li> <li>• Meals, including special diets.</li> <li>• Regular nursing services.</li> <li>• Costs of special care units (such as intensive or coronary care units).</li> <li>• Drugs and medications.</li> <li>• Lab tests.</li> <li>• X-rays and other radiology services.</li> <li>• Necessary surgical and medical supplies.</li> <li>• Use of appliances, such as wheelchairs.</li> <li>• Operating and recovery room costs.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See <a href="#">Section 2</a> for more information about transplants.</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.</li> <li>• Physician services.</li> </ul>	<p>All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 1-800-336-6709) Monday-Friday 8:30 a.m.-5 p.m. EST. The facility must be Medicare approved and part of the Humana Transplant Network.</p>
	<p><u>Out of Network</u> \$100 copayment per admission</p>
	<p>You pay nothing for physician services at a hospital.</p> <p>Humana Group PPO Plan requests prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 1-800-833-3301).</p>
	<p>All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 1-800-336-6709) Monday-Friday 8:30 a.m.-5 p.m. EST. The facility must be Medicare approved and part of the Humana Transplant Network.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Inpatient mental health care</b>  Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</p>	<p><u>In Network</u></p> <p>\$100 copayment per admission</p> <p>Humana Group PPO Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 1-800-833-3301).</p> <p><u>Out of Network</u></p> <p>\$100 copayment per admission</p> <p>Humana Group PPO Plan requests prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 1-800-833-3301).</p>

**Benefits chart - your covered services****What you must pay when you get these covered services****Skilled nursing facility care**

For more information about skilled nursing facility care, see [Section 2](#).

You are covered for days 1-100 for each benefit period\*. Prior hospital stay is not required. Covered services include, but aren't limited to, the following:

- Semiprivate room or a private room if medically necessary.
- Meals, including special diets.
- Regular nursing services.
- Physical therapy, occupational therapy, and speech therapy.
- Drugs, including substances that are naturally present in the body, such as blood clotting factors.
- Blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.
- Medical and surgical supplies.
- Laboratory tests.
- X-rays and other radiology services.
- Use of appliances, such as wheelchairs.
- Physician services.

\*A benefit period begins the day you go to a skilled nursing facility. The benefit period ends when you have not received skilled nursing care for 60 days in a row. (See [Section 11](#) for a definition of "Benefit period").

In Network

You pay nothing for days 1-100

Humana Group PPO Plan requires prior authorization for inpatient skilled nursing services. Call 1-800-523-0023, (TTY# 1-800-833-3301).

Out of Network

You pay nothing for days 1-100

Humana Group PPO Plan requests prior authorization for inpatient skilled nursing services. Call 1-800-523-0023, (TTY# 1-800-833-3301).

**Benefits chart - your covered services****What you must pay when you get these covered services****Inpatient services (when the hospital or skilled nursing facility days aren't or are no longer covered)**In Network

You are covered for these services according to Medicare guidelines.

You pay nothing

For more information about inpatient services, see Section 2. Covered services include, but aren't limited to, the following:

- Physician services.
- Tests (X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
- Leg, arm, back, and neck braces.
- Trusses.
- Artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Physical therapy, occupational therapy, and speech therapy.

Out of Network

You are covered for these services according to Medicare guidelines.

You pay nothing

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Home health agency care</b> For more information about home health agency care, see <a href="#">Section 2</a>. Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aid services.</li> <li>• Physical therapy, occupational therapy, and speech therapy.</li> <li>• Medical social services.</li> <li>• Medical equipment and supplies.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing</p> <p>Humana Group PPO Plan requires prior authorization for home health services. Call 1-800-523-0023,(TTY# 1-800-833-3301).</p> <p><u>Out of Network</u></p> <p>You pay nothing</p> <p>Humana Group PPO Plan requests prior authorization for home health services. Call 1-800-523-0023, (TTY# 1-800-833-3301).</p>
<p><b>Hospice care</b> For more information about hospice services, see <a href="#">Section 2</a>. Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare.</li> <li>• Home care.</li> </ul> <p>Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>When you enroll in a Medicare-certified Hospice program, your hospice services are paid by Medicare, not your Medicare Advantage plan (see <a href="#">Section 2</a> for more information about hospice services).</p>

Benefits chart - your covered services	What you must pay when you get these covered services
<b>Outpatient Services</b>	
<b>Physician services, including doctor office visits</b>	<u>In Network</u>
Covered services include, but aren't limited to, the following:	\$10 copayment for each primary care physician office visit
<ul style="list-style-type: none"> <li>Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center.</li> </ul>	\$20 copayment for each specialist office visit
<ul style="list-style-type: none"> <li>Consultation, diagnosis, and treatment by a specialist.</li> </ul>	You pay nothing for drugs administered in a physician office.
<ul style="list-style-type: none"> <li>Second opinion by another plan provider prior to surgery.</li> </ul>	<u>Out of Network</u>
<ul style="list-style-type: none"> <li>Outpatient hospital services.</li> </ul>	\$10 copayment for each primary care physician office visit
<ul style="list-style-type: none"> <li>Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).</li> </ul>	\$20 copayment for each specialist office visit
<ul style="list-style-type: none"> <li>Drugs administered in a physician office.</li> </ul>	You pay nothing for drugs administered in a physician office.
<ul style="list-style-type: none"> <li>Smoking cessation (Medicare covered)</li> </ul>	

**Benefits chart - your covered services****What you must pay when you get these covered services****Allergy serum and injections**In Network

You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Out of Network

You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

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<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Chiropractic services</b></p> <p>Covered services, include, but aren't limited, to the following:</p> <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation.</li> <li>• Routine services are limited to 20 visits per plan year.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing for Medicare covered chiropractic services</p> <p>\$20 copayment for each primary care physician office visit for routine services</p> <p>\$20 copayment for each specialist office visit for routine services</p> <p>\$20 copayment for each immediate care facility visit for routine services</p> <p><u>Out of Network</u></p> <p>You pay nothing for Medicare covered chiropractic services</p> <p>\$20 copayment for each primary care physician office visit for routine services</p> <p>\$20 copayment for each specialist office visit for routine services</p> <p>\$20 copayment for each immediate care facility visit for routine services</p>
<p><b>Podiatry services</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs.</li> <li>• Limited to Medicare covered services.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>

**Benefits chart - your covered services****What you must pay when you get these covered services****Outpatient mental health care including partial hospitalization services**In Network

Covered services include, but are not limited to, the following:

- Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.
- "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Out of Network

You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Benefits chart - your covered services	What you must pay when you get these covered services
<b>Outpatient substance abuse services</b>	<p data-bbox="862 264 1013 298"><u>In Network</u></p> <p data-bbox="862 342 1385 520">You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p data-bbox="862 600 1073 634"><u>Out of Network</u></p> <p data-bbox="862 678 1385 850">You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>
<b>Observation</b>	<p data-bbox="862 905 1013 938"><u>In Network</u></p> <p data-bbox="862 982 1357 1052">\$50 copayment for each outpatient hospital visit</p> <p data-bbox="862 1131 1073 1165"><u>Out of Network</u></p> <p data-bbox="862 1209 1357 1270">\$50 copayment for each outpatient hospital visit</p>

Benefits chart - your covered services	What you must pay when you get these covered services
<b>Outpatient surgery</b>	<p data-bbox="862 262 1013 296"><u>In Network</u></p> <p data-bbox="862 338 1399 411">\$50 copayment for each primary care physician office visit.</p> <p data-bbox="862 449 1349 522">\$50 copayment for each specialist office visit.</p> <p data-bbox="862 560 1364 634">\$50 copayment for each immediate care facility visit.</p> <p data-bbox="862 672 1373 745">\$50 copayment for each ambulatory surgical center visit.</p> <p data-bbox="862 783 1357 856">\$50 copayment for each outpatient hospital visit.</p> <p data-bbox="862 894 1373 968">You pay nothing for nail debridement in all places of treatment.</p> <p data-bbox="862 1005 1073 1039"><u>Out of Network</u></p> <p data-bbox="862 1077 1399 1150">\$50 copayment for each primary care physician office visit.</p> <p data-bbox="862 1188 1349 1262">\$50 copayment for each specialist office visit.</p> <p data-bbox="862 1299 1364 1373">\$50 copayment for each immediate care facility visit.</p> <p data-bbox="862 1411 1373 1484">\$50 copayment for each ambulatory surgical center visit.</p> <p data-bbox="862 1522 1357 1596">\$50 copayment for each outpatient hospital visit.</p> <p data-bbox="862 1633 1373 1707">You pay nothing for nail debridement in all places of treatment.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Ambulance services</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Ambulance services to an institution, a hospital or skilled nursing facility.</li> <li>• From an institution to another institution.</li> <li>• From an institution to your home.</li> <li>• Services dispatched through 911, where other means of transportation could endanger your health.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p><b>Emergency care</b></p> <p>For more information, see <a href="#">Section 2</a>.</p> <p>You are covered for Emergency care World-wide.</p>	<p><u>In Network</u></p> <p>\$50 copayment for each emergency room visit.</p> <p>You do not pay the emergency room visit copayment if you are admitted to the hospital within 24 hours for the same condition, or if you are at a hospital outside of the United States.</p> <p><u>Out of Network</u></p> <p>\$50 copayment for each emergency room visit.</p> <p>You do not pay the emergency room visit copayment if you are admitted to the hospital within 24 hours for the same condition, or if you are at a hospital outside of the United States.</p> <p>World-wide: \$50 copayment for each emergency room visit. Benefit does not apply to your annual out-of-pocket maximum or your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Urgently needed care</b></p> <p>For more information, see <a href="#">Section 2</a>.</p> <p>You are covered for Urgently needed care World-wide.</p>	<p><u>In Network</u></p> <p>\$10 copayment for each primary care physician office visit</p> <p>\$20 copayment for each specialist office visit</p> <p>You pay nothing for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$10 copayment for each primary care physician office visit</p> <p>\$20 copayment for each specialist office visit</p> <p>You pay nothing for each immediate care facility visit</p>
<p><b>Outpatient rehabilitation services</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Physical therapy.</li> <li>• Occupational therapy.</li> <li>• Speech and language therapy.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>

Benefits chart - your covered services	What you must pay when you get these covered services
<b>Medical supplies</b>	<u>In Network</u>
	You pay nothing
	<u>Out of Network</u>
	You pay nothing
<b>Durable medical equipment and related supplies</b>	<u>In Network</u>
Covered services include, but aren't limited to, the following:	You pay nothing
<ul style="list-style-type: none"> <li>• Wheelchairs.</li> <li>• Crutches, hospital beds.</li> <li>• IV infusion pump.</li> <li>• Oxygen equipment.</li> <li>• Nebulizer.</li> <li>• Walker.</li> </ul>	Humana Group PPO Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 1-800-833-3301)
See definition of "durable medical equipment" in <u>Section 11</u> .	<u>Out of Network</u>
	You pay nothing
	Humana Group PPO Plan requests prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 1-800-833-3301)

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Prosthetic devices and related supplies, other than dental</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Colostomy bags and supplies directly related to colostomy care.</li> <li>• Pacemakers.</li> <li>• Braces, prosthetic shoes and artificial limbs.</li> <li>• Breast prostheses, including a surgical brassiere after a mastectomy.</li> <li>• Certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices.</li> <li>• Some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more detail.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing</p> <p>Humana Group PPO Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 1-800-833-3301)</p> <p><u>Out of Network</u></p> <p>You pay nothing</p> <p>Humana Group PPO Plan requests prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 1-800-833-3301)</p>
<p><b>Diabetes self-monitoring, training and supplies for all people who have diabetes</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• One pair per plan year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.</li> <li>• Self-management training is covered under certain conditions.</li> <li>• For persons at risk of diabetes, fasting plasma glucose tests are covered as often as medically necessary.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing for training if these are the only services rendered. If other services are being rendered in addition to these services, your cost will depend on the service.</p> <p>Benefit does not apply to your annual deductible.</p> <p>You pay nothing for diabetic monitoring supplies from a durable medical equipment provider or a pharmacy</p> <p>Medicare covered diabetic monitoring supplies received at a pharmacy do not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing for training if these are the only services rendered. If other services are being rendered in addition to these services, your cost will depend on the place of service.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
	<p>Benefit does not apply to your annual deductible.</p> <p>You pay nothing for diabetic monitoring supplies from a durable medical equipment provider or a pharmacy.</p> <p>Medicare covered diabetic monitoring supplies received at a pharmacy do not apply to your annual deductible.</p>
<p><b>Medical nutrition therapy</b></p> <p>For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• X-rays.</li> <li>• Radiation therapy.</li> <li>• Surgical supplies, such as dressings.</li> <li>• Supplies, such as splints and casts.</li> <li>• Laboratory tests.</li> <li>• Blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.</li> <li>• Advanced imaging.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>
<p><b>Preventive Care and Screening Tests</b></p> <p><b>Bone-mass measurements for qualified individuals that are at risk of bone loss or osteoporosis</b></p> <p>Services are covered once per year or more frequently if medically necessary.</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Procedures to identify bone mass, detect bone loss, or determine bone quality.</li> <li>• Physician's interpretation of the results.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Colorectal screening</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy or screening barium enema as an alternative once per year.</li> <li>• Fecal occult blood test, once per year.</li> <li>• Screening colonoscopy or screening barium enema as an alternative once per year.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>
<p><b>Immunizations</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine.</li> <li>• Flu shots once a year in the fall or winter.</li> <li>• Hepatitis B vaccine, if you are at high or intermediate risk of getting Hepatitis B.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Mammography screening</b></p> <ul style="list-style-type: none"> <li>One screening per year.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>
<p><b>Pap test, pelvic exam, and clinical breast exam</b></p> <ul style="list-style-type: none"> <li>Services are covered once per year.</li> </ul>	<p><u>In Network</u></p> <p>\$10 copayment for each primary care physician office visit.</p> <p>\$20 copayment for each specialist office visit.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>\$10 copayment for each primary care physician office visit.</p> <p>\$20 copayment for each specialist office visit.</p> <p>Benefit does not apply to your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Prostate cancer screening exams</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam once per year.</li> <li>• Prostate Specific Antigen (PSA) test once per year.</li> </ul>	<p><u>In Network</u></p> <p>\$10 copayment for each primary care physician office visit.</p> <p>\$20 copayment for each specialist office visit.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>\$10 copayment for each primary care physician office visit.</p> <p>\$20 copayment for each specialist office visit.</p> <p>Benefit does not apply to your annual deductible.</p>
<p><b>Cardiovascular disease testing</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Blood tests for the detection of cardiovascular disease.</li> <li>• Abnormalities associated with an elevated risk of cardiovascular disease.</li> </ul> <p>Covered as frequently as medically necessary.</p>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Physical exams</b></p> <p>You are covered for one routine physical per year.</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Counseling on diet, exercise, substance abuse, injury prevention.</li> <li>• Height and weight at intervals according to provider's clinical discretion.</li> <li>• Blood pressure.</li> <li>• Vision screening at provider's discretion.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p>Benefit does not apply to your annual deductible.</p>
<b>Other Services</b>	
<p><b>Renal (Kidney) dialysis</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Outpatient dialysis treatments including dialysis treatments when temporarily out of the service area, as explained in <u>Sections 2 and 3</u>.</li> <li>• Inpatient dialysis treatments if you are admitted to a hospital for special care.</li> <li>• Self-dialysis training includes training for you and anyone helping you with your home dialysis treatments.</li> <li>• Home dialysis equipment and supplies. See "Durable medical equipment and related supplies" for details.</li> <li>• Certain home support services, such as visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply. See "Home health agency care" for details.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Chemotherapy drugs</b></p>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>
<p><b>Acupuncture</b></p> <ul style="list-style-type: none"> <li>• Limited to 20 visits per plan year.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>
<p><b>Massage Therapy</b></p> <ul style="list-style-type: none"> <li>• Limited to 20 visits per plan year.</li> </ul>	<p><u>In Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p> <p><u>Out of Network</u></p> <p>You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<b>Additional Benefits (Mandatory supplemental benefits)</b>	
<p><b>Dental services</b></p> <p>Covered services by a dentist or oral surgeon are limited to the following:</p> <ul style="list-style-type: none"> <li>• Surgery of the jaw or related structures.</li> <li>• Setting fractures of the jaw or facial bones.</li> <li>• Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.</li> <li>• Services that would be covered when provided by a doctor.</li> </ul>	<p><u>In Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered dental services</p> <p>\$50 copayment for each specialist office visit for surgical services.</p> <p><u>Out of Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered dental services</p> <p>\$50 copayment for each specialist office visit for surgical services.</p>
<p><b>Hearing services</b></p> <p>Covered services are limited to the following:</p> <ul style="list-style-type: none"> <li>• Diagnostic hearing exams.</li> </ul>	<p><u>In Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered hearing services</p> <p><u>Out of Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered hearing services</p>
<p><b>Vision care</b></p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for eye care.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</li> </ul>	<p><u>In Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered vision services.</p> <p>\$50 copayment for each specialist office visit for surgical services.</p> <p>You pay nothing for eyeglasses or contact lenses following cataract surgery.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> </ul>	<p><u>Out of Network</u></p> <p>\$20 copayment for each specialist office visit for Medicare covered vision services.</p> <p>\$50 copayment for each specialist office visit for surgical services.</p> <p>You pay nothing for eyeglasses or contact lenses following cataract surgery.</p>

### **PEIA Retiree Assistance Program**

The PEIA retiree assistance program offers retirees the opportunity for decreased premiums as well as modifications to their benefits. If PEIA determines you qualify for this assistance, please refer to the chart below for your modified benefit information. For more information regarding qualifications, please contact PEIA.

#### **Medical**

- \$300 Maximum out-of-pocket.
- \$2 co-payment for each Primary Care Physician office visit.
- \$5 co-payment for each Specialist office visit.

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
<p><b>Health and wellness education programs</b></p> <p><b>SilverSneakers<sup>(R)</sup> Fitness Program</b></p> <p>You are covered for membership to a participating SilverSneakers<sup>(R)</sup> Fitness Program.</p> <p>Your benefits include:</p> <ul style="list-style-type: none"> <li>• A basic fitness center membership at a participating location near you with access to the basic amenities.</li> <li>• Custom designed, low impact classes designed to improve your body's strength and flexibility.</li> <li>• On-site advisors to act as your contact for information and personalized service.</li> <li>• Social events.</li> <li>• Self-directed SilverSneakers<sup>(R)</sup> Steps program with focus on improving strength and mobility, available to members that are not located within a 15-mile radius of a fitness center.</li> </ul>	<p>You pay nothing for these programs.</p> <p>See below for state eligibility:</p> <p>The SilverSneakers<sup>(R)</sup> Fitness program is available in all states except Arizona and Pennsylvania.</p>
<p><b>Silver&amp;Fit<sup>TM</sup> Fitness Program</b></p> <p>You are covered for membership to a participating fitness club.</p> <p>Your benefits include:</p> <ul style="list-style-type: none"> <li>• A basic fitness center membership at a participating location near you with access to the basic amenities.</li> <li>• Custom designed, low impact classes designed to improve your body's strength and flexibility.</li> <li>• Social events.</li> </ul>	<p>The Silver &amp; Fit<sup>TM</sup> program is available in the states of Arizona and Pennsylvania.</p>

<b>Benefits chart - your covered services</b>	<b>What you must pay when you get these covered services</b>
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<p><b>QuitNet<sup>(R)</sup> smoking-cessation program</b></p> <p>Comprehensive smoking cessation services include:</p> <ul style="list-style-type: none"> <li>• Web based or telephonic counseling/coaching.</li> <li>• QuitGuide, and QuitTips email support.</li> <li>• Over-the-counter nicotine replacement therapy which includes Nicoderm<sup>(R)</sup> Patch, Nicoderm<sup>(R)</sup> Gum, and Commit<sup>(R)</sup> Lozenge products.</li> </ul> <p>You can enroll by phone at 1-888-572-4074 (TTY # 1-800-833-3301), 8 a.m. to 12 a.m., Monday through Friday, or 8:30 a.m. to 5 p.m., Saturday, Eastern Standard time. Or enroll online at <a href="http://quitnet.com/humana">quitnet.com/humana</a>.</p>	<p>The QuitNet<sup>(R)</sup> smoking-cessation program is available in all states.</p>
<p><b>Humana Active Outlook<sup>(R)</sup></b></p> <p>Medicare members benefit from exclusive lifestyle enrichment through our award-winning program. Medicare members get the following benefits of Humana Active Outlook at no additional cost.</p>	<p>Humana Active Outlook<sup>(R)</sup> is available in all states.</p>
<p><b>Humana Active Outlook Printed Resources</b></p> <ul style="list-style-type: none"> <li>• <b>HAO Magazine</b>, our quarterly award-winning publication with inspiring stories for active, fun, healthy living</li> <li>• <b>Live it up! Digest</b>, a quarterly publication to help members with chronic conditions manage their health</li> </ul>	
<p><b>Humana Active Outlook Website</b></p> <p><b>HumanaActiveOutlook.com</b>, your source for custom senior health information and interactive tools on the Web.</p>	

**Benefits chart - your covered services****What you must pay when you get these covered services****Humana Active Outlook Classes and Seminars**

Learn more about how you can live a healthier lifestyle! Join other members to learn about brain fitness, the right way to exercise, how to eat healthy, computers and technology, managing conditions, and understanding your healthcare experience in our local health and wellness classes in select communities. And don't miss out on our health education seminar, where you'll learn about condition-specific topics such as diabetes or osteoporosis. Watch presentations from experts, get a health screening, hear the latest information on health conditions, and talk with professionals who can answer your questions.

**Heal!** Personalized Health Programs  
Condition-specific information on managing diabetes, cardiovascular health, cancer, COPD, weight, chronic conditions, and back health and care.

**LifeWorks** Member Assistance Program**HumanaFirst<sup>(R)</sup> 24 Hour Nurse Advice Line**

HumanaFirst<sup>(R)</sup> 24 Hour Nurse Advice Line is available in all states.

As a Humana member, you have access to health information, guidance, and support. Whether you have an immediate health concern or questions about a particular medical condition, call HumanaFirst for expert advice and guidance at no additional cost to you.

Just call 1-800-622-9529  
(TTY # 1-800-833-3301) to talk with a nurse.

## Benefits chart - your covered services

## What you must pay when you get these covered services

### Why call HumanaFirst?

You may not have health concerns or medical questions very often but when you do, call the HumanaFirst Nurse Advice Line. We're your health information and support team:

- If you need a refresher course in changing your bandage after a recent surgery.
- If you've been diagnosed with a medical condition such as diabetes or cancer.
- If you have a fever at 3:00 a.m. in the morning.

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### What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered for you as a member, we want to help. Please call Customer Service department. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See [Section 8](#) for information about making a complaint.

### Can your benefits change during the year?

**Generally your benefits will not change during the year. The Medicare Program doesn't allow us to decrease your benefits during the plan year.** The only time your benefits may decrease is at the beginning of the next plan year. The Medicare Program must approve any decreases we make in your benefits. We will tell you in November if there are going to be any increases or decreases in your benefits for the next plan year that begins on January 1.

**At any time during the year, the Medicare Program can change its national coverage.** Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. If your benefits increase, the Original Medicare Plan will pay for the benefit for the rest of the plan year. In those cases, you will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let you know in advance if you will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

## **Prescription Drug (Part B) Benefits**

### **Prescription Drugs that are covered under the Original Medicare Plan**

(these drugs are covered for everyone with Medicare)

"Drugs" includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but aren't limited to, the following:

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services.
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by Humana Insurance Company.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen<sup>(R)</sup>) or Epoetin alfa, and Darboetin Alfa (Aranesp<sup>(R)</sup>).

**You pay nothing for Medicare covered Part B drugs.**

## **Section 4 - Your Costs for This Plan**

### **Paying your monthly plan premium**

If you have any questions about our Plan premiums or the payment programs, please call PEIA customer service at 304-558-7850 or toll free at 1-888-680-7342.

### **Paying your share of the cost when you get covered services or drugs**

#### **What are "deductibles," and "copayments?"**

- The "**deductible**" is the amount you must pay for the health care services or drugs you receive before our Plan begins to pay its share of your covered services or drugs.
- A "**copayment**" is a payment you make for your share of the cost of certain covered services or drugs you get. A co-payment is a set amount per service or drug. You pay it when you get the service or drug. The Benefits Chart in Section 3 gives your co-payments for covered services.

**What is your cost for services that aren't covered under our Plan?**

You are responsible to pay the full cost of care and services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination made for the service. you may call Customer Service and tell us you would like a decision on whether the service will be covered.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the original Medicare limits. For example, you may have to pay the full cost of any medical care received outside of the United States after our Plan's payments reach the foreign travel benefit limit. you can call members Services when you want to know how much of your benefit limit you have already used.

**Using all of your insurance coverage**

If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care expenses. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if you have additional health insurance.

## **Section 5 - Your rights and responsibilities as a member of our Plan**

### **Introduction to your rights and protections**

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit [www.medicare.gov](http://www.medicare.gov) on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

### **Your right to be treated with dignity, respect and fairness**

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service at the phone number on the back of your membership card. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or your local Office for Civil Rights.

## **Your right to the privacy of your medical records and personal health information**

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number on the back of your membership card. The Plan will release your information to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

## **Your right to see providers, get covered services, within a reasonable period of time**

As explained in this booklet, if you see a provider who accepts Medicare assignment as well as Humana's payment terms and conditions, you will pay a cost-share based on a contracted amount. If you see a provider who accepts Medicare assignment but does not accept Humana's payment terms and conditions, you will pay a cost-share based on Original Medicare's fee schedule.

You have the right to choose a provider for your care. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. [Section 2](#) explains how to use providers to get the care and services you need.

Sometimes the selection of providers is limited in certain geographic areas or in some specialties. Call the Customer Service number on your Humana ID card to get more instructions. Be sure to contact providers before you see them to make sure they accept Medicare assignment and have agreed to accept payment from Humana.

### **Your right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination. Organization determinations are discussed in [Section 8](#).

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate.

## **Your right to use advance directives (such as a living will or a power of attorney)**

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives** ." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 1 of this booklet tells how to contact your SHIP, which stands for State Health Insurance Assistance Program. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the state agency in your state that handles dealing with Advance Directives (please see the State specific data sheet at the end of the EOC).

## **Your right to make complaints**

You have the right to make a complaint if you have concerns or problems related to your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See Section 8 for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

## **Your right to get information about our Plan, plan providers, health care coverage, and costs**

This booklet tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Customer Service at the number on the back of your membership card. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. *We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision.* See Section 8 for more information about filing an appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our Plan health care providers and their qualifications, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Service at the phone number on the back of your membership card. You have the right under law to have a written/binding advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

At Humana, a process called utilization management (UM) is used to determine whether a service or treatment is covered according to national medical guidelines. Humana does not reward doctors and other individuals for denying coverage or withholding service. In fact, utilization management actually helps Humana make sure you get the preventive care and medically necessary services you need.

Humana has a quality improvement program that focuses on clinical and preventive care and administrative functions of the health plan. You may obtain a written QI program description by contacting Humana calling 1-800-4-HUMANA (1-800-448-6262). For a report on how goals are being met in individual markets, or to provide input into the QI Program, mail a request to the following address: Humana Quality Management Department, Progress Report, 321 West Main, WFP 20, Louisville, KY 40202

### **How to get more information about your rights**

If you have questions or concerns about your rights and protections, please call Customer Service at the number on the back of your membership card. You can also get free help and information from your SHIP (contact information for your SHIP at the end of this booklet). You can also visit [www.medicare.gov](http://www.medicare.gov) on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **What you do if you think you have been treated unfairly or your rights are not being respected?**

If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (contact information for your SHIP is at the end of this booklet).

## **Your responsibilities as a member of our Plan**

Your responsibilities include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and your co-payments/coinsurance for your covered services. You must pay for services that aren't covered.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number on the back of your membership card.

## **Your right to get information about our Plan.**

You have the right to get information from us about our Plan. This includes information about our financial condition. To get any of this information, call Customer Service at the number on the back of your membership card.

## **6 - General Exclusions**

### **Introduction**

The purpose of this section is to tell you about medical care and services and items that aren't covered ("excluded") or are limited by our Plan. The list below tells about general exclusions and limitations. The Benefits Chart in Section 3 explains in greater detail about restrictions, exclusions or limitations that apply to certain services specific to this plan.

**If you get services, items and drugs that are not covered, you must pay for them yourself.**

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items or drugs that we should have paid or covered (appeals are discussed in Section 8).

### **What services are not covered or are limited by our Plan?**

In addition to any exclusions or limitations described in the Benefits Chart in Section 3, or anywhere else in this booklet, **the following items and services aren't covered except as indicated by our Plan in the Benefits Chart in Section 3:**

1. Services that aren't covered under the Original Medicare Plan.
2. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
3. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.

5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
8. Nursing care on a full-time basis in your home.
9. Custodial care, unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
10. Homemaker services.
11. Charges imposed by immediate relatives or members of your household.
12. Meals delivered to your home (see [Section 3](#) for more information).
13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
15. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered (see [Section 3](#) for more information).
16. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in [Section 3](#)) and is limited according to Medicare guidelines (see [Section 3](#) for more information).
17. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines (see [Section 3](#) for more information).
18. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

20. Hearing aids (see Section 3 for more information).
21. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services (see Section 3 for more information).
22. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
23. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
24. Acupuncture.
25. Naturopath services.
26. Services provided to veterans in **V**eterans **A**ffairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
27. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

## **Section 7 - How to file a Grievance**

### **What is a Grievance?**

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal, as described in Section 8 of this manual, because grievances do not involve problems related to approving or paying for care, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility SNF, Home Health Agency HHA, or Comprehensive Outpatient Rehabilitation Facility CORF services ending too soon.

If we will not give you the services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 8.

### **What types of problems might lead to your filing a grievance?**

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Customer Service.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in Section 8.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance". In certain cases, you have the right to ask for a "fast grievance", meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 8.

## Filing a grievance with our Plan

If you have a complaint, please call the phone number for **Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our grievance process.** You or your representative may file your concerns in writing or verbally. Please follow the grievance process described below.

### Grievance Process:

You or your representative may file your concerns in writing or verbally. Please follow the grievance process described below. Grievances must be filed within 60 days of occurrence. Direct your written request to the address listed in Section 1 for Grievances.

You may also file a verbal grievance by calling the customer service number on the back of your membership card.

When filing a grievance, please provide the following information: Your name, address, telephone number and member identification number, you or your authorized representative's signature, date and summary of the grievance, any previous contact with us, and a description of the action you are requesting. If you or your authorized representative require assistance in preparing and submitting your written grievance, contact our Customer Service Department at the number on the back of your membership card. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

### Expedited grievance process:

You may request an expedited grievance if:

- You disagree with our decision to extend the timeframe to make an initial standard decision or reconsideration.
- We deny your request for a 72-hour/fast expedited initial decision.
- We deny your request for a 72-hour/fast expedited appeal.

You may make your request orally by calling the number listed in Section 1. You may fax your request to the fax number listed in Section 1. You may mail your request to the address listed in Section 1 for grievances.

Note: If you mail the request, we will provide oral acknowledgement upon receipt.

We will make a determination within 24 hours of receipt of your request.

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

### **For quality of care problems, you may also complain to the QIO**

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See [Section 1](#) for more information about the QIO.

### **How to file a quality of care complaint with the QIO**

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See [Section 1](#) for more information about how to file a quality of care complaint with the QIO.

## **Section 8 - What to Do if you have Complaints about Your Services and Benefits**

### **Medical Services and Benefits**

#### **Introduction**

This section gives the rules for making complaints about services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with your care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to the Original Medicare section of your *Medicare & You* Handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare & You* Handbook, please call 1-800 Medicare to get a copy.

#### **How to make complaints in different situations**

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

**PART 1. Complaints about what benefit or service we will approve or what we will pay for.**

**PART 2. Complaints if you think you are asked to leave the hospital too soon.**

**PART 3. Complaints if you think your Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.**

If you want to make a complaint about any situation not listed above, you may file a grievance. **For more information about grievances, see [Section 7](#).**

**PART 1. Complaints about what benefit or service the Plan will approve or what the Plan will pay for.**

#### **What are "complaints about your services or payment for your care"?**

- If you are not getting the care you want, and you believe that this care is covered by the Plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

### **What is an organization determination?**

An organization determination is our **initial decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our initial decision is to deny your request, you may **appeal** the decision by going to Appeal Level 1 (later in this section). You may also appeal if we fail to make a timely initial decision on your request.

**When we make an "organization determination", we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to your specific situation.** This booklet and any amendments you may receive describe the benefits and services covered by the Plan, including any limits on these services. This booklet also lists services that are "not covered" by the Plan.

### **Who may ask for an "organization determination" about your medical care or payment?**

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under **Organization Determinations** in Section 1 of this booklet. Please call us at the phone number shown under **Organization Determinations** for more information. You also have the right to have a lawyer act for you. You can get your own lawyer, or find a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact the agency or agencies listed in the state specific data sheets at the end of the Evidence of Coverage as "Agencies that may give free legal service".

## **Do you have a request for medical care that needs to be decided more quickly than the standard time frame?**

A decision about whether we will pay for or approve medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is also called an "expedited organization determination". You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

### **Asking for a standard decision**

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the address listed under **Organization Determinations** in Section 1 of this booklet.

### **Asking for a fast decision**

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us. Or you may send or fax us a written request to the fax number or address listed under **Organization Determinations** in Section 1 of this booklet. After normal business hours, holidays and weekends, please fax your request or call the number and leave a detailed message. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that you don't need a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance". If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 7.

## What happens next when you request an initial decision?

1. For a decision about payment for care you already received.

We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called "reconsideration".)

2. For a standard decision about medical care.

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance". If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. For a fast decision about medical care.

If you receive a "fast" decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it - sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

**Appeal Level 1: If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration" .**

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" initial decision. While the process for deciding on a standard or fast appeal is the same as a standard or fast determination, the place where the appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

### **Getting information to support your appeal**

If we need your help in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get your doctor's records or your doctor's opinion to support your request. You may need to give your doctor a written request to get information.

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under **Appeals** in Section 1 of this booklet. You can also deliver additional information in person to the address listed under **Appeals** in Section 1 of this booklet. You also have the right to ask us for a copy of the information we have regarding your appeal. You may call or write us at the numbers or address listed under **Appeals** in Section 1 of this booklet. We are allowed to charge a fee for copying and sending this information to you.

### **How do you file your appeal of the organization determination?**

The rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an 'organization determination' about medical care or payment?" However, providers who do not have a contract with the Plan must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

### **How soon must you file your appeal?**

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you may call or write us at the phone number or address listed under **Appeals** in Section 1 of this booklet.

## What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" decision. While the process for deciding on a standard or fast appeal is the same as a standard or fast determination, the place where the appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

### How soon must we decide on your appeal?

1. For a decision about payment for care you already received.

After we receive your appeal, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

### What happens next if we rule completely in your favor?

1. For a decision about payment for care you already received.

We must pay within 60 days of the day we received your appeal.

2. For a standard decision about medical care.

We must authorize or provide your requested care within 30 days of receiving your appeal. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

3. For a fast decision about medical care.

We must authorize or provide your requested care within 72 hours of receiving your appeal - or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

**Appeal Level 2: If on your Level 1 appeal, we do not rule completely in your favor, your appeal will automatically be reviewed by an independent review entity .**

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (**C**enters for **M**edicare & **M**edicaid **S**ervices), the government agency that runs the Medicare program, and is not part of the Plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal:

1. For a decision about payment for care you already received.

We must forward your appeal to the independent review entity within 60 days of the date we received your Level 1 appeal.

2. For a standard decision about medical care.

We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a fast decision about medical care.

We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed **under Appeals** in Section 1 of this booklet. We are allowed to charge you a fee for copying and sending this information to you.

**How soon must the independent review entity decide?**

1. For an appeal about payment for care, the independent review entity has 60 days to make a decision.
2. For a standard appeal about medical care, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast appeal about medical care, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

**If the independent review entity decides completely in your favor:**

The independent review entity will tell you in writing about its decision.

1. For an appeal about payment for care.

We must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care.

We must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a fast appeal about medical care.

We must authorize or provide the care you requested within 72 hours after receiving the decision.

**Appeal Level 3: If the entity that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge.**

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

**How soon will the Judge make a decision?**

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

**If the Judge decides in your favor.**

We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

**Appeal Level 4: If the Judge does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council**

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

**How soon will the Council make a decision?**

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

**If the Council decides in your favor**

We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

**Appeal Level 5: If the Medicare Appeal Council does not rule completely in your favor, you may ask for a review by a Federal Court**

You may file an appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

## How soon will the Judge make a decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final.

## Part 2. Complaints (appeals) if you think you are being discharged from the hospital too soon.

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

### Information you should receive during your hospital stay

Within two days of admission as an inpatient, someone at the hospital must give you a notice called the Important Message from Medicare (call our Plan Customer Service phone number listed in [Section 1](#) or 1-800 MEDICARE(1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end - only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

### Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

## What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

## Getting QIO review of your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review".
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

## What happens if the QIO decides in your favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable copayments or deductibles).

## What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

### **What happens if you appeal the QIO decision?**

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care as long as it is medically necessary (except for any applicable copayments or deductibles).

### **What if you do not ask the QIO for a review by the deadline?**

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable copayments or deductibles).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

### **PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services is ending too soon.**

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

#### **Information you will receive during your SNF, HHA or CORF stay**

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call the Plan Customer Service phone number in [Section 1](#) or 1-800 Medicare (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end - only that you received and understood the notice.**

#### **Getting QIO review of our decision to end coverage**

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

#### **How soon do you have to ask for QIO review?**

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

### **What will happen during the QIO's review?**

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end (call the Plan Customer Service phone number in [Section 1](#) or 1-800-Medicare to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

The QIO will make a decision within one full day after it receives all the information it needs.

### **What happens if the QIO decides in your favor?**

We will continue to cover your SNF, HHA or CORF services for as long as they are medically necessary (except for any applicable copayments or deductibles).

### **What happens if the QIO agrees that your coverage should end?**

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

### **What happens if you appeal the QIO decision?**

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

### **What if you do not ask the QIO for a review by the deadline?**

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services for as long as they are medically necessary.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable copayments or deductibles).

## **Section 9 - Ending your Membership**

Ending your membership in our Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

### **Voluntarily ending your membership**

Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. Contact Customer Service or your benefit administrator before you disenroll.

### **Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself .**

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect.

While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan.

If you must receive services outside of your Plan's limitations, neither we nor the Medicare program will pay for these services, with just a few exceptions. If you have any questions, please call Customer Service at the number listed on the back of your membership card.

If you happen to be hospitalized on the day your membership ends, please call Customer Service to find out if your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call Customer Service at the number listed on the back of your membership card.

### **We cannot ask you to leave the Plan because of your health .**

We *cannot* ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

## **Involuntarily ending your membership**

If any of the following situations occur, we will end your membership in our Plan:

- If you move out of the service area or are away from the service area for more than 6 months in a row. If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row you cannot remain a member of the Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do *not* stay continuously enrolled in "Medicare A and B".
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

## **You have the right to make a complaint if we end your membership in our Plan**

If we end your membership in our Plan, we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

## **Section 10 - Legal Notices**

### **Notice about governing law**

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of your state may apply.

### **Notice about nondiscrimination**

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

### **Notice of Coordination of Benefits**

#### **Why do we need to know if you have other coverage?**

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all the rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

#### **Who pays first when you have other coverage?**

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through Plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan *and* your Humana plan. In other situations, such as for benefits that are not covered by the Plan, you may get your care outside of the Plan.

## **Employer and employee organization group health plans**

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or end-stage renal disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

## **Employer and employee organization group health plans for people who are disabled**

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if

- You are under age 65, and
- You do not have ESRD, and
- You do not have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple employer plan where any employer participating in the Plan has 100 or more employees. If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

## **Employer and employee organization group health plans for people with End Stage Renal Disease ("ESRD")**

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to you thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

## **Workers' Compensation and similar programs**

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this Evidence of Coverage for services rendered in connection with your job-related illness or injury.

## **Accidents and injuries**

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay", no-fault, automobile, accident or liability coverage are available to you, the "Med Pay", no-fault, automobile, accident or liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment.

If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. Humana will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

## **Non-duplication of benefits**

We will not duplicate any benefits or payments you receive under any automobile, accident, liability or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the Subrogation and Third Party Recovery section for more information on our recovery rights.

## **More information**

This is just a brief summary. Whether we pay first or second - or at all - depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government, *Medicare and Other Health Benefits: Your Guide to Who Pays First*. It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the *Code of Federal Regulations*.

## **Appeal rights**

If you disagree with any decision or action by the Plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Section 8 of this Evidence of Coverage.

## **Notice of Subrogation and Third Party Recovery**

### **Subrogation**

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness or condition. We are entitled to exercise the same rights of subrogation and recovery that are accorded to the Medicare Program under the Medicare Secondary Payer rules.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive, including but not limited to the following:

1. Any award, settlement, benefits or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third party tortfeasor or person, entity or insurer responsible for indemnifying the third party tortfeasor;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or
4. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our representatives and to take any actions or steps necessary to secure our lien, including but not limited to:

1. Responding to requests for information about any accidents or injuries;
2. Responding to our requests for information and providing any relevant information that we have requested; and
3. Participating in all phases of any legal action we commence in order to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

## **Reimbursement**

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under your plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in the Plan.

**Antisubrogation rules do not apply**

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.

We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness, or condition.

## **Section 11 - Definition of Some Words Used in This Book**

**Advanced imaging services** - Means Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

**Ambulatory surgical center** - Is a freestanding facility that provides medical surgical procedures on an outpatient basis for the prevention, diagnosis and treatment of an injury or illness. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board and is Medicare certified and licensed by the proper authority.

**Appeal** - An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. Section 8 explains about appeals, including the process involved in making an appeal.

**Benefit period** - For both the Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any SNF for 60 days in a row. If you go to the SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays.

You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. (Section 5 tells what is meant by skilled care.)

**Centers for Medicare & Medicaid Services (CMS)** - The Federal agency that runs the Medicare program. Section 1 explains how to contact CMS.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** - Means a facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

**Computed Tomography Imaging (CT/CAT) Scan** - Combines the use of a digital computer together with a rotating X-ray device to create detailed cross sectional images of different organs and body parts.

**Cost-sharing** - Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount the Plan may impose before services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

**Coverage determination** - The Plan has made a coverage determination when it makes a decision about the benefits you can receive under the Plan, and the amount that you must pay for those benefits. You need to call or write to the Plan to ask for a formal decision about the coverage if you disagree.

**Covered services** - The general term we use in this booklet to mean all of the health care services and supplies that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 3.

**Customer Service** - A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Customer Service.

**Deductible** - The amount of money you must first pay for covered services before the Plan will begin paying for your covered services.

**Diagnostic mammogram** - Means a radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

**Disenroll or disenrollment** - The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 9 tells about disenrollment.

**Durable medical equipment** - Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

**Emergency care** - Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 2 tells about emergency services.

**Evidence of coverage and disclosure information** - This document, along with your enrollment form, which explains your coverage, and what we must do, and explains your rights and what you have to do as a member of our Plan.

**Freestanding dialysis center** - Means a freestanding facility that provides dialysis on an outpatient basis. This type of facility does not provide inpatient room and board and is Medicare certified and licensed by the proper authority.

**Freestanding lab** - Means a freestanding facility that provides laboratory tests on an outpatient basis for the prevention, diagnosis and treatment of an injury or illness. This type of facility does not provide inpatient room and board and is Medicare certified and licensed by the proper authority.

**Freestanding radiology (imaging) center** - Is a freestanding facility that provides one or more of the following services on an outpatient basis for the prevention, diagnosis and treatment of an injury or illness: X-rays; nuclear medicine; radiation oncology. This type of facility does not provide inpatient room and board and is Medicare certified and licensed by the proper authority.

**Grievance** - A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve payment or coverage disputes. See [Section 7](#) for more information about grievances.

**Humana's National Transplant Network (NTN)** - Is a network of Humana approved facilities all of which are also Medicare approved facilities.

**Immediate care facility** - Is a facility established to diagnose and treat an unforeseen injury or illness on an outpatient basis. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board.

**Inpatient care** - Health care that you get when you are admitted to a hospital.

**Magnetic Resonance Angiography (MRA)** - Is a noninvasive method and a form of magnetic resonance imaging (MRI) that can measure blood flow through blood vessels.

**Magnetic Resonance Imaging (MRI)** - Is a diagnostic imaging modality that uses a magnetic field and computerized analysis of induced radio frequency signals to noninvasively image body tissue.

**Medically necessary** - Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

**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 permanent kidney failure (who need dialysis or a kidney transplant).

**Medicare Advantage Organization** - Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Part C". They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage.

**Medicare Advantage Plan** - A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans in the same service area. We are a Medicare Advantage Organization.

**"Medigap" (Medicare supplement insurance) policy** - Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

**Member (member of our Plan, or "plan member")** - A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Non-plan provider or non-plan facility** - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Non-plan providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our Plan or Original Medicare.

**Nuclear medicine** - Means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

**Observation** - Means a stay in a hospital for less than 24 hours if:

1. you have not been admitted as a registered bed patient;
2. you are physically detained in an emergency room, treatment room, observation room or other such area; or
3. you are being observed to determine whether an inpatient confinement will be required.

**Organization determination** - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

**Original Medicare** - Some people call it "traditional Medicare" or "fee-for-service" Medicare. The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Plan provider - "Provider"** is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

**Primary Care Physician (PCP)** - A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

**Positron Emission Tomography (PET) Scan** - Is a medical imaging technique. It involves injecting the patient with an isotope and using a PET scanner to detect the radiation emitted.

**Prior authorization** - Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Section 3.

**Quality Improvement Organization (QIO)** - Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 1 for information about how to contact the QIO in your state and Section 7 for information about making complaints to the QIO.

**Rehabilitation services** - These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

**Screening mammogram** - Means a radiological procedure for early detection of breast cancer, and includes a physician's interpretation of the results.

**Service area** - Section 1 tells about our Plan's service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

**Supplemental Security Income (SSI)** - A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently needed care** - Section 2 explains about "urgently needed" services. These are different from emergency services.

**We, our and us** - Means the Plan.

**You and your** - Means the person covered by the Plan.

**Section 12 - State Specific Information**

<b>State</b>	<b>Alabama</b>
SHIPName and Contact Information	Alabama Department of Senior Services 770 Washington Avenue RSA Plaza, Suite 470 Montgomery, AL 36130-1851 Phone: 1-800-AGELINE (1-800-243-5463) (toll free) or (334) 242-5743 (local) <a href="http://www.alabamaageline.gov/healthcare">http://www.alabamaageline.gov/healthcare</a>
Quality Improvement Organization	Alabama Quality Assurance Foundation Two Perimeter Park Drive, Suite 200 West Birmingham, AL 35243 Phone: 1-205-970-1600 (local) <a href="http://www.aqaf.com/">http://www.aqaf.com/</a>
State Medicaid Office	Medicaid Agency of Alabama P.O. Box 5624 Montgomery, AL 36103-5624 Phone: 1-800-362-1504 (toll free) or 1-334-242-5000 (local)

<b>State</b>	<b>Alaska</b>
SHIPName and Contact Information	Alaska State Health Insurance Assistance Program (SHIP) 3601 C St., Suite 310 Anchorage, AK 99503 Phone: 1-800-478-6065 (toll free; in-state calls only) or 1-907-269-3680 (local) TTY: 1-907-269-3691 <a href="http://medicare.alaska.gov">medicare.alaska.gov</a>
Quality Improvement Organization	Mountain Pacific Quality Health Foundation 4241 B Street, Suite 303 Anchorage, AK 99503 Phone: 1-877-561-3202 (toll free) or 1-907-561-3202 (local) <a href="http://www.mpqhf.org/">http://www.mpqhf.org/</a>
State Medicaid Office	Alaska Department of Health and Social Services - Senior and Disabilities Services 751 Old Richardson Hwy, Suite 100a Fairbanks , AK 99701 Phone: 1-800-770-1672 (toll free) or 1-907-451-5045 (local) TTY: 1-907-451-5093

<b>State</b>	<b>Arizona</b>
SHIP Name and Contact Information	Arizona State Health Insurance Assistance Program 1789 West Jefferson Street, 950A Phoenix, AZ 85007 Phone: 1-800-432-4040 (SHIP Hotline) or 1-602-542-6595 (local) <a href="http://www.azdes.gov/aaa/programs/ship/default.asp">http://www.azdes.gov/aaa/programs/ship/default.asp</a>
Quality Improvement Organization	Health Services Advisory Group, Inc. 1600 East Northern Ave., Suite 100 Phoenix, AZ 85020 Phone: 1-800-359-9909 (toll free) or (602) 264-6382 (local) <a href="http://www.hsag.com/">http://www.hsag.com/</a>
State Medicaid Office	AHCCCS 801 E. Jefferson Phoenix, AZ 85034 Phone: 1-800-654-8713 (toll free) or 1-602-417-5437 (local)

<b>State</b>	<b>Arkansas</b>
SHIP Name and Contact Information	Senior Health Insurance Information Program 1200 West Third Street Little Rock, AR 72201 Phone: 1-800-224-6330 (toll free) or 1-501-371-2782 (local) <a href="http://insurance.arkansas.gov/seniors/homepage.htm">http://insurance.arkansas.gov/seniors/homepage.htm</a>
Quality Improvement Organization	Arkansas Foundation for Medical Care 401 West Capitol, Suite 410 Little Rock, AR 72201 Phone: 1-888-987-1200 (toll free) or 1-501-375-1200 (local) or 1-888-354-9100 (Medicare helpline) TTY: 1-888-285-1131 <a href="http://www.afmc.org/HTML/index/index.aspx">http://www.afmc.org/HTML/index/index.aspx</a>
State Medicaid Office	Division of Medical Services - Department of Human Services Donahey Plaza South, P.O. Box 1437 Slot S401 Little Rock, AR 72203-1437 Phone: 1-800-482-5431 (in-state toll free) or 1-501-682-8501 (local and out of state) or 1-800-482-8988 (Spanish in-state toll free) TTY: 1-501-682-1661

<b>State</b>	<b>California</b>
SHIPName and Contact Information	Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Drive, Suite 200 Sacramento, CA 95834-1992 Phone: 1-800-434-0222 (toll free) TTY: 1-800-735-2929 <a href="http://www.aging.ca.gov/aaa/guidance/health_insurance_counseling_and_advocacy_program_index.asp">http://www.aging.ca.gov/aaa/guidance/health_insurance_counseling_and_advocacy_program_index.asp</a>
Quality Improvement Organization	Health Services Advisory Group 700 N. Brand Blvd, Suite 370 Glendale, CA 91203 Phone: 1-818-409-9229 (local) or 1-866-800-8749 (toll free) or 1-800-841-1602 (Appeals helpline) TTY: 1-800-881-5980 <a href="http://www.hsag.com/">http://www.hsag.com/</a>
State Medicaid Office	Department of Health Care Services -Medi-Cal P.O. Box 13029 Sacramento, CA 95813-4029 Phone: 1800-541-5555 (toll free in state only) or 1-916-636-1200 (local)

<b>State</b>	<b>Colorado</b>
SHIPName and Contact Information	Senior Health Insurance Assistance Program 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 1-888-696-7213 (toll free) or 1-303-629-4940(local) or 1-866-665-9668 (Spanish) TTY: 1-303 894-7880 <a href="http://www.dora.state.co.us/insurance/senior/senior.htm">www.dora.state.co.us/insurance/senior/senior.htm</a>
Quality Improvement Organization	Colorado Foundation for Medical Care 23 Iverness Way East, Suite 100 Englewood, CO 80112-5708 Phone: 1-800-727-7086 (toll-free) or 1-303-695-3300 (local)
State Medicaid Office	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203 Phone: 1-800-221-3943 (toll free) or 1-303- 866-3513 (local) TTY: 1-800-659-2656

<b>State</b>	<b>Connecticut</b>
SHIP Name and Contact Information	Connecticut Program for Health Insurance Assistance, Outreach, Information & Referral Counseling and Eligibility Screening (CHOICES) 25 Sigourney Street, 10 <sup>th</sup> Floor Hartford, CT 06106 Phone: 1-800-994-9422 (toll free; in-state calls only) or 1-860-424-5274 (local) <a href="http://www.ct.gov/agingservices">http://www.ct.gov/agingservices</a>
Quality Improvement Organization	Qualidigm 1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067-3454 Phone: 1-800-553-7590 (toll free) or 1-860-632-2008 (local) <a href="http://www.qualidigm.org/">http://www.qualidigm.org/</a>
State Medicaid Office	State of Connecticut Department of Social Services 25 Sigourney Street Hartford, CT 06106-5033 Phone: 1-800-842-1508 (toll free; in-state calls only) or 1-860-424-4908 (local) TTY: 1-800-842-4524
State Pharmacy Assistance Program	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (ConnPace) PO Box 5011 Hartford, CT 06102 Phone: 1-800-423-5026 (toll free) or 1-860-269-2029 (local) <a href="http://www.connpace.com">http://www.connpace.com</a>

<b>State</b>	<b>Delaware</b>
SHIP Name and Contact Information	ELDERinfo 841 Silverlake Blvd. Dover, DE 19904 Phone: 1-800-336-9500 (toll free: in-state calls only) or 1-302-647-7364 (local) <a href="http://delawareinsurance.gov/departments/elder/eldinde x.shtml">http://delawareinsurance.gov/departments/elder/eldinde x.shtml</a>
Quality Improvement Organization	Quality Insights of Delaware Baynard Building, Suite 100 3411 Silverside Road Wilmington, DE 19810-4182 Phone: 1-866-475-9669 (toll free) or 1-302-478-3600 (local) <a href="http://www.quide.org/de/">http://www.quide.org/de/</a>
State Medicaid Office	Division of Services for Aging and Adults with Physical Disabilities Lewis Building 1901 N. DuPont Highway New Castle, DE 19720 Phone: 1-800-223-9074 (toll free) or 1-302-255-9390 (local) TTY: 1-302-453-3837
State Pharmacy Assistance Program	Delaware Prescription Assistance Program P.O. Box 950 New Castle, DE 19720-0950 Phone: 1-800-996-9969 (option 2, then option 1) <a href="http://www.dhss.delaware.gov/dss/dmma/dpap.html">http://www.dhss.delaware.gov/dss/dmma/dpap.html</a>

<b>State</b>	<b>District of Columbia</b>
SHIP Name and Contact Information	Health Insurance Counseling Project 2136 Pennsylvania Ave. NW Washington, DC 20052 Phone: 1-202-739-0668 (local) TTY: 1-202-973-1079 <a href="http://dcoa.dc.gov/dcoa/cwp">http://dcoa.dc.gov/dcoa/cwp</a>
Quality Improvement Organization	Delmarva Foundation for Medical Care 2175 K Street NW, Suite 250 Washington, DC 20037 Phone: 1-800-937-3362 (toll free) or 1-202-293-9650 (local) TTY: 1-800-735-2258 <a href="http://www.dcqio.org/">http://www.dcqio.org/</a>
State Medicaid Office	Department of Health 825 North Capitol Street, NE Suite 5135 Washington, DC 20002 Phone: 1-202-442-5988 (local) TTY: 1-800-367-9559 <a href="http://doh.dc.gov">http://doh.dc.gov</a>

<b>State</b>	<b>Florida</b>
SHIP Name and Contact Information	SHINE 4040 Esplanade Way Tallahassee, FL 32399-7000 Phone: 1-800-963-5337 (toll free) or 1-850-414-2060 (local) TTY: 1-800-955-8771 <a href="http://www.floridaSHINE.org">http://www.floridaSHINE.org</a>
Quality Improvement Organization	FMQAI 5201 West Kennedy Blvd, Suite 900 Tampa, FL 33609-1822 Phone: 1-800-844-0795 (toll free) or 1-813-354-9111 (local) <a href="http://www.fmqai.com/">http://www.fmqai.com/</a>
State Medicaid Office	Agency for Health Care Administration of Florida 2727 Mahan Drive Tallahassee, FL 32308 Phone: 1-888-419-3456 (toll free; in-state calls only)

<b>State</b>	<b>Georgia</b>
SHIP Name and Contact Information	GeorgiaCares 2 Peachtree Street, NW, Suite 9-210 Atlanta, GA 30303 Phone: 1-800-669-8387 (toll free) or 1-866-552-4464 (toll free) TTY: 1-404-657-1929 <a href="http://www.dhr.georgia.gov">www.dhr.georgia.gov</a>
Quality Improvement Organization	Georgia Medical Care Foundation 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346 Phone: 1-800-982-0411 (toll free) or 1-404-982-0411 (local) <a href="http://www.gmcf.org/">http://www.gmcf.org/</a>
State Medicaid Office	Georgia Department of Community Health 2 Peachtree Street, Atlanta, GA 30303 Phone: 1-404-656-4507 (local)

<b>State</b>	<b>Hawaii</b>
SHIP Name and Contact Information	Sage PLUS 250 South Hotel Street, Room 406 Honolulu, HI 96813 Phone: 1-888-875-9229 (toll free) or 1-808-586-7299 (local) TTY: 1-866-810-4379 <a href="http://www.hawaii.gov/health/eoa">www.hawaii.gov/health/eoa</a>
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation 1360 S. Beretania Street, Suite 501 Honolulu, HI 96814 Phone: 1-800-524-6550 (toll free) or 1-808-545-2550 (local) <a href="http://www.mpqhf.org/">http://www.mpqhf.org/</a>
State Medicaid Office	Med-Quest 601 Kamokila Blvd, Toom 518 Kapolei, HI 96707 Phone: 1-808-586-5390 (local) TTY: 1-808-692-7182
State Pharmacy Assistance Program	Hawaii Rx Plus PO Box 700220 1001 Kamokila Blvd, Ste 317 Kapolei, HI 96709 Phone: 1-808-692-7999 (local, Oahu) or 1-866-878-9769 (toll free neighbor islands) <a href="http://hawaii.gov/dhs/quicklinks/dhs/rx_plus">http://hawaii.gov/dhs/quicklinks/dhs/rx_plus</a>

<b>State</b>	<b>Idaho</b>
SHIPName and Contact Information	Senior Health Insurance Benefit Advisors of Idaho (SHIBA) 700 West State Street, 3rd floor Boise, ID 83720-0043 Phone: 1-800-247-4422 (toll free; in-state calls only) or 1-208-334-4250 (local) <a href="http://www.doi.idaho.gov/shiba/shwelcome.aspx">http://www.doi.idaho.gov/shiba/shwelcome.aspx</a>
Quality Improvement Organization	QualisHealth 720 Park Blvd., Suite 120 Boise, ID 83712 Phone: 1-800-488-1118 (toll free) or 1-208-343-4617 (local) <a href="http://www.qualishealthmedicare.org/">http://www.qualishealthmedicare.org/</a>
State Medicaid Office	Idaho Department of Health and Welfare 1720 Westgate Drive Boise, ID 83704 Phone: 1-877-456-1233 (toll free) TTY: 1-208-334-0901

<b>State</b>	<b>Illinois</b>
SHIPName and Contact Information	Senior Health Insurance Program of Illinois (SHIP) 320 West Washington Street, 4th Floor Springfield, IL 62767-0001 Phone: 1-800-548-9034 (toll free; in-state calls only) or 1-217-785-9021 (local) TTY: 1-217-524-4872 <a href="http://www.insurance.illinois.gov">http://www.insurance.illinois.gov</a>
Quality Improvement Organization	Illinois Foundation for Quality Health Care (IFMC-IL) 711 Jorie Blvd, Suite 301 Oak brook, IL 60523-4425 Phone: 1-800-647-8089 (toll free) or 1-630-928-5800 (local) <a href="http://www.ifqhc.org">http://www.ifqhc.org</a>
State Medicaid Office	Illinois Health Connect 1375 East Woodfield Rd, Suite 600 Schaumburg, IL 60173-5418 Phone: 1-877-912-1999 (toll free) or TTY: 1-866-565-8577
State Pharmacy Assistance Program	Illinois Cares RX Illinois Department on Aging P.O. Box 19003 Springfield, IL 62794-9003 Phone: 1-800-252-8966 (Senior help line) or 1-800-624-2459 (24 hr automated information) TTY: 1-888-206-1327 <a href="http://www.illinoiscaresrx.com">www.illinoiscaresrx.com</a>

<b>State</b>	<b>Indiana</b>
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 714 W. 53 <sup>rd</sup> Street Anderson, IN 46013 Phone: 1-800-452-4800 (toll free) or 1-765-608-2318 (local) TTY: 1-866-846-0139 <a href="http://www.medicare.in.gov">www.medicare.in.gov</a>
Quality Improvement Organization	Health Care Excel, Inc. 2629 Waterfront Parkway East Drive, Suite 200 Indianapolis, IN 46214 Phone: 1-800-288-1499 (toll free) or 1-317-347-4500 (Indianapolis) or 1-812-234-1499 (Terre Haute) <a href="http://www.hce.org/">http://www.hce.org/</a>
State Medicaid Office	Family and Social Services Administration of Indiana 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46207-7083 Phone: 1-800-889-9949 (toll free) or 1-317-233-9435 (local) <a href="http://www.in.gov/fssa/elderly/hoosierx/">http://www.in.gov/fssa/elderly/hoosierx/</a>
State Pharmacy Assistance Program	Hoosier RX P.O. Box 6224 Indianapolis, IN 46206-6224 Phone: 1-866-267-4679 (toll free, in state only) or 1-317-234-1381 (local) <a href="http://www.in.gov/fssa/ompp/4248.htm">http://www.in.gov/fssa/ompp/4248.htm</a>

<b>State</b>	<b>Iowa</b>
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIIP) 330 Maple St. Des Moines, IA 50319 Phone: 1-877-955-1212 (toll free in state only) or 1-515-281-5705 <a href="http://www.therightcalliowa.gov">www.therightcalliowa.gov</a>
Quality Improvement Organization	Iowa Foundation for Medical Care 1776 West Lakes Parkway West Des Moines, IA 50266 Phone: 1-800-383-2856 (toll free) or 1-515-223-2900 (local) <a href="http://www.internetifmc.com/">http://www.internetifmc.com/</a>
State Medicaid Office	Iowa Department of Human Services PO Box 36510 Des Moines, IA 50315 Phone: 1-800-338-8366 (toll free) or 1-515-725-1003 (local)

<b>State</b>	<b>Kansas</b>
SHIP Name and Contact Information	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ave. Topeka, KS 66603-3404 Phone: 1-800-860-5260 (toll free) or 1-316-337-7386 (local) TTY: 1-785-291-3167 <a href="http://www.agingkansas.org/">http://www.agingkansas.org/</a>
Quality Improvement Organization	Kansas Foundation for Medical Care, Inc. 2947 S.W. Wanamaker Drive Topeka, KS 66614-4193 Phone: 1-800-423-0770 (toll free) or 1-785-273-2552 (local) <a href="http://www.kfmc.org/">http://www.kfmc.org/</a>
State Medicaid Office	Department of Social and Rehabilitation Services of Kansas 915 SW Harrison St. Topeka, KS 66612 Phone: 1-785-296-3959 (local) TTY: 1-785-296-1491 <a href="http://www.srskansas.org/">http://www.srskansas.org/</a>

<b>State</b>	<b>Kentucky</b>
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3W-F Frankfort, KY 40621 Phone: 1-877-293-7447 (toll free) or 1-502-564-6930 (local) TTY: 1-888-642-1137 <a href="http://www.chfs.ky.gov/dail/ship/htm">http://www.chfs.ky.gov/dail/ship/htm</a>
Quality Improvement Organization	Health Care Excel 1941 Bishop Lane, Suite 400 Louisville, KY 40218 Phone: 1-800-288-1499 (toll free) or 1-502-454-5112 (Louisville) or 1-502-564-5472 (Frankfort) <a href="http://www.hce.org/">http://www.hce.org/</a>
State Medicaid Office	Cabinet for Health Services of Kentucky 275 East Main Street Frankfort, KY 40621 Phone: 1-502-564-4321 (local) TTY: 1-800-627-4702

<b>State</b>	<b>Louisiana</b>
SHIP Name and Contact Information	Senior Health Insurance Information Program (SHIIP) 1702 North 3rd St Baton Rouge, LA 70802 Phone: 1-800-259-5301 (toll free; in-state calls only) or 1-225-342-5301 (local) <a href="http://www.ldi.state.la.us/Health/SHIP/index.htm">http://www.ldi.state.la.us/Health/SHIP/index.htm</a>
Quality Improvement Organization	Louisiana Health Care Review, Inc. 8591 United Plaza Blvd., Suite 270 Baton Rouge, LA 70809 Phone: 1-800-433-4958 (toll free) or 1-225-926-6353 (local) <a href="http://www.lhcr.org/">http://www.lhcr.org/</a>
State Medicaid Office	Louisiana Department of Health and Hospital 465 North 7th St, Suite 300 Baton Rouge, LA 70802 Phone: 1-225-219-1917 (local)

<b>State</b>	<b>Maine</b>
SHIP Name and Contact Information	Maine State Health Insurance Assistance Program (SHIP) 11 State House Station 32 Blossom Lane, 2nd Floor Augusta, ME 04333 Phone: 1-877-353-3771 (toll free; in-state calls only) or 1-207-621-0087 (local) TTY: 1-800-606-0215 <a href="http://maine.gov/dhhs/oes/hiap/index.shtml">http://maine.gov/dhhs/oes/hiap/index.shtml</a>
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820 Phone: 1-800-772-0151 (toll free) or 1-603-749-1641 (local) <a href="http://www.nhcqf.org/">http://www.nhcqf.org/</a>
State Medicaid Office	Office of MaineCare Services 11 State House Station 442 Civic Center Drive Augusta, ME 04333-0011 Phone: 1-800-977-6740 (option 2) (toll free) or 1-207-287-9202 (main number) TTY: 1-800-606-0215
State Pharmacy Assistance Program	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 442 Civic Center Drive State House Station #11 August, ME 04333 Phone: 1-866-796-2463 <a href="http://www.maine.gov/dhhs/oes/hiap/del_exp.htm">http://www.maine.gov/dhhs/oes/hiap/del_exp.htm</a>

<b>State</b>	<b>Maryland</b>
SHIP Name and Contact Information	Maryland Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007 Baltimore, MD 21201 Phone: 1-800-243-3425 (toll free; in-state calls only) or 1-410-767-1100 (local) TTY: 1-800-252-5533 <a href="http://www.mdoa.state.md.us/">http://www.mdoa.state.md.us/</a>
Quality Improvement Organization	Delmarva Foundation for Medical Care, Inc. 9240 Centreville Road Easton, MD 21601 Phone: 1-800-999-3362 (toll free) or 1-410-822-0697 (local) <a href="http://www.mdqio.org/">http://www.mdqio.org/</a>
State Medicaid Office	The Maryland Department of Aging 301 West Preston St. Baltimore, MD 21201 Phone: 1-800-243-3425 (toll free) or 1-410-767-5800 (local) TTY: 1-800-201-7165
State Pharmacy Assistance Program	Maryland SPDAP c/o Pool Administrators 100 Great Meadow Rd., Suite 705 Wethersfield, CT 06109 Phone: 1-800-551-5995 (toll-free) TTY: 1-800-877-5156 <a href="http://www.marylandspdap.com">www.marylandspdap.com</a>

<b>State</b>	<b>Massachusetts</b>
SHIP Name and Contact Information	Serving Health Information Needs of Elders (SHINE) 1 Ashburton Place, 5 <sup>th</sup> Floor Boston, MA 02108 Phone: 1-800-243-4636 (toll free) or 1-617-727-7750 (local) TTY: 1-800-872-0166 <a href="http://www.mass.gov/elders">www.mass.gov/elders</a>
Quality Improvement Organization	MassPRO 235 Winter Street Waltham, MA 02451-1231 Phone: 1-800-334-6776 (toll free; in-state calls only) or 1-781-890-0011 (local) <a href="http://www.masspro.org/">http://www.masspro.org/</a>
State Medicaid Office	Executive Office of Elder Affairs One Ashburton Place, Room 517 Boston, MA 02108 Phone: 1-800-882-2003 (toll free; in-state calls only) 1-617-727-7750 (local) TTY: 1-800-872-0166
State Pharmacy Assistance Program	Massachusetts Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 Phone: 1-800-243-4636 (toll free) TTY: 1-877-610-0241 <a href="http://www.800ageinfo.com">www.800ageinfo.com</a>

<b>State</b>	<b>Michigan</b>
SHIP Name and Contact Information	MMAP PO Box 30676 Lansing, MI 48909-8176 Phone: 1-800-803-7174 (toll free) or 1-517-886-1242 (local) <a href="http://www.mmapinc.org">www.mmapinc.org</a>
Quality Improvement Organization	MPRO 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 Phone: 1-800-365-5899 (toll free) or 1-248-465-7300 (local) <a href="http://www.mprom.org/">http://www.mprom.org/</a>
State Medicaid Office	Michigan Department Community Health Capitol View Building 201 Townsend Street Lansing, MI 48913 Phone: 1-517-373-3740 (local) TTY: 1-800-649-3777

<b>State</b>	<b>Minnesota</b>
SHIP Name and Contact Information	Minnesota State Health Insurance Assistance Program/Senior Link P.O. Box 64976 540 Cedar St St. Paul, MN 55164-0976 Phone: 1-800-333-2433 (toll-free) or 1-651-431-2500 (local) TTY: 711 (In-State only) <a href="http://www.mnaging.org/advisor/SLL_SHIP.htm">http://www.mnaging.org/advisor/SLL_SHIP.htm</a>
Quality Improvement Organization	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 Phone: 1-877-787-2847 (toll free) or 1-952-854-3306 (local) TTY: 1-800-627-3529 <a href="http://www.stratishealth.org/index.html">http://www.stratishealth.org/index.html</a>
State Medicaid Office	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976 Phone: 1-800-333-2433 (toll free) or 1-651-431-2500 (local) or 1-800-882-6262 (toll free) TTY: 1-800-627-3529

<b>State</b>	<b>Mississippi</b>
SHIP Name and Contact Information	MS State Health Insurance Assistance Program (SHIP) 750 North State Street Jackson, MS 39202 Phone: 1-601-359-4956 (local) TTY: 1-800-676-4154 <a href="http://www.mdhs.state.ms.us/aas_info.html#MICAP">http://www.mdhs.state.ms.us/aas_info.html#MICAP</a>
Quality Improvement Organization	Information and Quality Healthcare 385B Highland Colony Parkway, Suite 504 Ridgeland, MS 39157 Phone: 1-800-844-0500 (toll free) or 1-601-957-1575 (local) <a href="http://www.iqh.org">http://www.iqh.org</a>
State Medicaid Office	Mississippi Division of Medicaid Sillers Building, 550 High Street, Suite 1000 Jackson, MS 39201-1399 Phone: 1-800-421-2408 (toll free) or 1-601-359-6050 (local) <a href="http://www.medicaid.ms.gov/">http://www.medicaid.ms.gov/</a>

<b>State</b>	<b>Missouri</b>
SHIP Name and Contact Information	CLAIM PO Box 690, Truman Bldg Jefferson City, MO 65102 Phone: 1-800-390-3330 (toll free) or 1-573-817-8320 (local) <a href="http://www.missouriclaim.org">www.missouriclaim.org</a>
Quality Improvement Organization	Primaris 200 North Keene Street Columbia, MO 65201 Phone: 1-800-347-1016 (toll free) or 1-573-817-8300 (local) TTY: 1-800-735-2966 <a href="http://www.primaris.org/">http://www.primaris.org/</a>
State Medicaid Office	Department of Social Services of Missouri 221 West High Street P.O. Box 1527 Jefferson City, MO 65102-1527 Phone: 1-800-392-2161 (toll free; in-state calls only) or 1-573-751-4815 (local) TTY: 1-800-735-2466
State Pharmacy Assistance Program	Missouri RX Plan 615 Howerton Court PO Box 6500 Jefferson City, MO 65102-6500 Phone: 1-800-375-1406 (toll free) or 1-573-751-3425 (local) <a href="http://www.morx.mo.gov">www.morx.mo.gov</a>

<b>State</b>	<b>Montana</b>
SHIP Name and Contact Information	Montana State Health Insurance Assistance Program (SHIP) PO Box 4210 Helena, MT 59601-4210 Phone: 1-800-551-3191 (toll free; in-state calls only) or 1-406-444-4077 TTY: 711 (In-State only) <a href="http://www.dphhs.mt.gov/sltc/services/aging/ship.shtml">http://www.dphhs.mt.gov/sltc/services/aging/ship.shtml</a>
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 Phone: 1-800-497-8232 (toll free) or 1-406-443-4020 (local) <a href="http://www.mpqhf.org/">http://www.mpqhf.org/</a>
State Medicaid Office	Montana Department of Public Health and Human Services Division of Child and Adult Health Resources 1400 Broadway, Cogswell Building Helena, MT 59620 Phone: 1-800-362-8312 (toll free; in-state calls only) or 1-406-444-4540 (local) TTY: 711 (In-State only)
State Pharmacy Assistance Program	Big Sky RX Program P.O. Box 202915 Helena, MT 59620-2915 Phone: 1-866-369-1233 (toll free in state) or 1-406-444-1233 (local) TTY: 711 (In-State only) <a href="http://www.bigskyrx.mt.gov">www.bigskyrx.mt.gov</a>

<b>State</b>	<b>Nebraska</b>
SHIP Name and Contact Information	Nebraska Senior Health Insurance Information Program (SHIIP) 941 O Street, Terminal Bldg Lincoln, NE 68508 Phone: 1-800-234-7119 (toll free) or 1-402-471-2201 (local) <a href="http://www.doi.ne.gov/shiip">http://www.doi.ne.gov/shiip</a>
Quality Improvement Organization	Cimro of Nebraska 1230 O Street, Suite 120 Lincoln, NE 68508 Phone: 1-800-458-4262 (toll free) or 1-402-476-1399 (local) <a href="http://www.cimronebraska.org/default.aspx">http://www.cimronebraska.org/default.aspx</a>
State Medicaid Office	Nebraska Department of Health and Human Services System P.O. Box 95026 Lincoln, NE 68509-5044 Phone: 1-800-430-3244 (toll free) or 1-402-471-3121 (local) TTY: 1-402-471-9570

<b>State</b>	<b>Nevada</b>
SHIP Name and Contact Information	State Health Insurance Advisory Program of Nevada 3416 Goni Road Bldg. D, #132 Carson City, NV 89706 Phone: 1-800-307-4444 (toll free) or 1-702-486-3478 (local) <a href="http://www.nvaging.net/ship/ship_main.htm">www.nvaging.net/ship/ship_main.htm</a>
Quality Improvement Organization	Health Insight 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118 Phone: 1-800-748-6773 (toll free) or 1-702-385-9933 (local) <a href="http://www.healthinsight.org/">http://www.healthinsight.org/</a>
State Medicaid Office	Nevada Department of Human Resources Aging Division 1210 S. Valley View Las Vegas, NV 89102 Phone: 1-800-992-0900 (toll free) or 1-775-684-7200 (local)
State Pharmacy Assistance Program	Nevada Senior RX Department of Health and Humana Services PO Box 21230 Carson City, NV 89721-2009 Phone: 1-866-303-6323 (toll free) or 1-775-687-7555 (local) <a href="http://dhhs.nv.gov/SeniorRx.htm">http://dhhs.nv.gov/SeniorRx.htm</a> or <a href="http://dhhs.nv.gov/disability.Rx.htm">http://dhhs.nv.gov/disability.Rx.htm</a>

<b>State</b>	<b>New Hampshire</b>
SHIP Name and Contact Information	NH SHIP- Servicelink Resource Center 129 Pleasant Street. Gallen State Office Park Concord, NH 03301-3857 Phone: 1-866-634-9412 (toll free; in-state calls only) TTY: 1-800-735-2964 <a href="http://www.servicelink.org">www.servicelink.org</a>
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820 Phone: 1-800-772-0151 (toll free) or 1-603-749-1641 (local) or 1-603-749-1195 (local) <a href="http://www.nhcqf.org/">http://www.nhcqf.org/</a>
State Medicaid Office	New Hampshire Department of Health and Human Services 105 Pleasant Street Concord, NH 03301 Phone: 1-800-852-3345 x8166 (toll free; in-state calls only) or 1-603-271-4322 (local)

<b>State</b>	<b>New Jersey</b>
SHIP Name and Contact Information	New Jersey Department of Health and Senior Services Division of Aging and Community Services P.O. Box 807 Trenton, NJ 08625-0807 Phone: 1-800-792-8820 (toll free; in-state calls only) or 1-877-222-3737 (toll free) <a href="http://www.state.nj.us/health/senior/ship.shtml">www.state.nj.us/health/senior/ship.shtml</a>
Quality Improvement Organization	Health Quality Strategies 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-5419 Phone: 1-800-624-4557 (toll free; in-state calls only) or 1-732-238-5570 (local) <a href="http://www.hqsi.org/index.html">http://www.hqsi.org/index.html</a>
State Medicaid Office	Department of Human Services of New Jersey Quakerbridge Plaza P.O. Box 712 Trenton, NJ 08625-0712 Phone: 1-800-356-1561 (toll free; in-state calls only) or 1-609-588-2600 (local) or 1-800-356-1561 (Spanish)
State Pharmacy Assistance Program	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services P.O. Box 715 Trenton, NJ 08625-0360 Phone: 1-800-792-9745 (toll free) or 1-609-292-7837 (local) <a href="http://www.state.nj.us/health/seniorbenefits">www.state.nj.us/health/seniorbenefits</a>
State Pharmacy Assistance Program	New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program PAAD-HAAD PO Box 715 Trenton, NJ 08625 Phone: 1-800-792-9745 (toll free) or 1-609-292-7837 (local) <a href="http://www.state.nj.us/health/seniorbenefits/paad.shtml">http://www.state.nj.us/health/seniorbenefits/paad.shtml</a>

<b>State</b>	<b>New Mexico</b>
SHIP Name and Contact Information	Benefits Counseling Program 2550 Cerrillos Road Santa Fe, NM 87505 Phone: 1-800-432-2080 (toll free; in-state calls only) or 1-505-476-4799 (local) <a href="http://www.nmaging.state.nm.us">www.nmaging.state.nm.us</a>
Quality Improvement Organization	New Mexico Medical Review Association 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109 Phone: 1-800-663-6351 (toll free) or 1-505-998-9898 (local) <a href="http://www.nmmra.org/">http://www.nmmra.org/</a>
State Medicaid Office	Human Services Department Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348 Phone: 1-888-997-2583 (toll free) or 1-800-432-6217 (Spanish)

<b>State</b>	<b>New York</b>
SHIP Name and Contact Information	Health Insurance Information, Counseling and Assistance Program (HIICAP) 2 Empire State Plaza Agency Bldg #2, 4th Floor Albany, NY 12223-1251 Phone: 1-800-701-0501 (toll free) or 1-800-342-9871 (toll free) <a href="http://www.aging.ny.gov">www.aging.ny.gov</a>
Quality Improvement Organization	Island Peer Review Organization - IPRO 1979 Marcus Avenue Lake Success, NY 11042-1002 Phone: 1-800-648-4776 (toll free) or 1-516-326-7767 (local) TTY: 1-866-326-6182 <a href="http://www.ipro.org">http://www.ipro.org</a>
State Medicaid Office	Benefits Counseling Program Corning Tower Building Empire State Plaza Albany, NY 12237 Phone: 1-800-541-2831 (toll free) or 1-518-486-9057 (local)
State Pharmacy Assistance Program	EPIC P.O. Box 15018 Albany, NY 12212-5018 Phone: 1-800-332-3742 (toll free) TTY: 1-800-290-9138 <a href="http://www.health.state.ny.us/health_care/epic/index.htm">http://www.health.state.ny.us/health_care/epic/index.htm</a>

<b>State</b>	<b>North Carolina</b>
SHIP Name and Contact Information	Seniors' Health Insurance Information Program (SHIIP) 11 South Boylan Avenue Raleigh, NC 27603 Phone: 1-800-443-9354 (toll free; in-state calls only) or 1-919-807-6900 (local) TTY: 1-800-735-2962 <a href="http://www.ncshiip.com">www.ncshiip.com</a>
Quality Improvement Organization	The Carolinas Center for Medical Excellence 100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598 Phone: 1-800-682-2650 (toll free) or 1-919-380-9860 (local) TTY: 1-800-735-2962 <a href="http://www2.thecarolinascenter.org/ccme/">http://www2.thecarolinascenter.org/ccme/</a>
State Medicaid Office	Division of Medical Assistance 1985 Umstead Dr Raleigh, NC 27603-2001 Phone: 1-919-855-4100(local) or 1-800-622-7030 (Care-Line Information and Referral Service: English/Spanish ) or 1-919-855-4400 (Spanish) TTY: 1-877-733-4851
State Pharmacy Assistance Program	NCRx P.O. Box 10068 Raleigh, NC 27690-2724 Phone: 1-888-488-6279 (toll free) <a href="http://www.ncrx.gov">www.ncrx.gov</a>

<b>State</b>	<b>North Dakota</b>
SHIP Name and Contact Information	State Health Insurance Counseling (SHIC) 600 East Boulevard, Dept 401 Bismarck, ND 58505-0320 Phone: 1-888-575-6611 (toll free; in-state calls only) or 1-701-328-2440 (local) TTY: 1-800-366-6888 <a href="http://www.nd.gov/ndins/consumer/">http://www.nd.gov/ndins/consumer/</a>
Quality Improvement Organization	North Dakota Health Care Review Inc 800 31 <sup>st</sup> Ave., SW Minot, ND 58701 Phone: 1-800-472-2902 (toll free) or 1-701-852-4231 (local) <a href="http://www.ndhcri.org/">http://www.ndhcri.org/</a>
State Medicaid Office	North Dakota Department of Human Services 600 East Blvd. Ave, Dept 325 Bismarck, ND 58505-0250 Phone: 1-800-472-2622 (toll free) or 1-701-328-2310 (local) TTY: 1-701-328-3480

<b>State</b>	<b>Ohio</b>
SHIP Name and Contact Information	Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town Street 3rd Floor, Suite 300 Columbus, OH 43215 Phone: 1-800-686-1578 (toll free) or 1-614-644-3458 (local) TTY: 1-614-644-3745 <a href="http://www.ohioinsurance.gov">http://www.ohioinsurance.gov</a>
Quality Improvement Organization	Ohio KePRO, Inc. Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 Phone: 1-800-589-7337 (toll free) or 1-216-447-9604 (local) <a href="http://www.ohiokepro.com/">http://www.ohiokepro.com/</a>
State Medicaid Office	The Ohio Department of Job and Family Services 30 E. Broad Street 32nd Floor Columbus, OH 43215 Phone: 1-877-852-0010 (toll free) or 1-614-466-2100 (local)

<b>State</b>	<b>Oklahoma</b>
SHIP Name and Contact Information	Senior Health Insurance Counseling Program 2401 N.W. 23rd, Suite 28 Oklahoma City, OK 73107 Phone: 1-800-763-2828 (toll free; in-state calls only) or 1-405-521-6628 (local) <a href="http://www.ok.gov/oid/">http://www.ok.gov/oid/</a>
Quality Improvement Organization	Oklahoma Foundation for Medical Quality, Inc. 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600 Phone: 1-800-522-3414 (toll free) or 1-405-840-2891 (local) <a href="http://www.ofmq.com/">http://www.ofmq.com/</a>
State Medicaid Office	Oklahoma Health Care Authority 4545 N. Lincoln Blvd, Suite 124 Oklahoma City, OK 73105 Phone: 1-800-522-0310 (toll free) or 1-405-522-7171 (local) or 1-405-522-7300 (local) TTY: 1-405-522-7179

<b>State</b>	<b>Oregon</b>
SHIP Name and Contact Information	Senior Health Insurance Benefits Assistance 250 Church St. SE, Suite 200 Salem, OR 97301-3921 Phone: 1-800-722-4134 (toll free) or 1-503-378-2014 (local) TTY: 1-800-735-2900 <a href="http://www.oregon.gov/DCBS/SHIBA/">http://www.oregon.gov/DCBS/SHIBA/</a>
Quality Improvement Organization	Acumentra Health 2020 SW Fourth Ave., Suite 520 Portland, OR 97201 Phone: 1-800-344-4354 (toll free) or 1-503-279-0100 (local) <a href="http://www.acumentra.org/">http://www.acumentra.org/</a>
State Medicaid Office	Oregon Department of Human Services 500 Summer Street, NE Salem, OR 94301 Phone: 1-800-527-5772 (toll free; in-state calls only) or 1-503-945-5772 (local) TTY: 503-945-5895

<b>State</b>	<b>Pennsylvania</b>
SHIP Name and Contact Information	APPRISE 555 Walnut Street, 5 <sup>th</sup> Floor Harrisburg, PA 17101-1919 Phone: 1-800-783-7067 (toll free) or <a href="http://www.aging.state.pa.us/aging/cwp.view">http://www.aging.state.pa.us/aging/cwp.view</a>
Quality Improvement Organization	Quality Insights of Pennsylvania 2601 Market Place Street, Suite 320 Harrisburg, PA 17110 Phone: 1-877-346-6180 (toll free) or 1-717-671-5425 (local) <a href="http://www.qipa.org/pa/">http://www.qipa.org/pa/</a>
State Medicaid Office	Department of Public Welfare of Pennsylvania Health and Welfare Building, Rm. 515 P.O. Box 2675 Harrisburg, PA 17105-2675 Phone: 1-800-692-7462 (toll free) or 1-717-787-1870 (local) TTY: 1-717-705-7103
State Pharmacy Assistance Program	PACE/PACENET P.O. Box 8806 Harrisburg, PA 17105 Phone: 1-800-225-7223 (toll free) or 1-717-651-3600 (local) TTY: 1-800-222-9004 <a href="http://www.pacecares.fhsc.com/">http://www.pacecares.fhsc.com/</a>

<b>State</b>	<b>Puerto Rico</b>
SHIP Name and Contact Information	State Health Insurance Assistance Program P.O. Box 191179 San Juan, PR 00919-1179 Phone: 1-877-725-4300 (toll free San Juan, Ponce) or 1-800-981-7735 (toll free Maytag) or 1-787-721-6121 (local) <a href="http://www.oppea.gobierno.pr">www.oppea.gobierno.pr</a>
Quality Improvement Organization	QI PRO, Inc. 2 Ponce De Leon Mercantil Plaza Bldg, Suite 709 San Juan, PR 00918 Phone: 1-800-981-5062 (toll free; in-state calls only) or 1-787-641-1240 (local) <a href="http://www.qipro.org/">http://www.qipro.org/</a>
State Medicaid Office	Medicaid Office of Puerto Rico and Virgin Island GPO Box 70184 San Juan, PR 00936 Phone: 1-787-250-0453 (local)

<b>State</b>	<b>Rhode Island</b>
SHIP Name and Contact Information	Senior Health Insurance Program John O. Pastore Complex, Hazard Building 74 West Road Cranston, RI 02920 Phone: 1-401-462-4444 (local) TTY: 1-401-462-0740 <a href="http://adrc.ohhs.ri.gov">http://adrc.ohhs.ri.gov</a>
Quality Improvement Organization	Quality Partners of Rhode Island 235 Promenade Street Suite 500, Box 18 Providence, RI 02908 Phone: 1-800-662-5028 (toll free) or 1-401-528-3200 (local) <a href="http://www.riqualitypartners.org/">http://www.riqualitypartners.org/</a>
State Medicaid Office	Department of Human Services of Rhode Island Louis Pasteur Building 600 New London Avenue Cranston, RI 02920 Phone: 1-800-984-8989 (toll free; in-state calls only) or 1-401-462-5300 (local) TTY: 1-401-462-3363
State Pharmacy Assistance Program	Rhode Island Prescription Assistance for the Elderly John O Pastore Center Hazard Building 74 West Road Cranston, RI 02920 Phone: 1-401-462-3000 (local) TTY: 1-401-462-0740 <a href="http://www.dea.state.ri.us//programs/prescription_assist.php">www.dea.state.ri.us//programs/prescription_assist.php</a>

<b>State</b>	<b>South Carolina</b>
SHIP Name and Contact Information	Insurance Counseling Assistance and Referrals for Elders Program (I-CARE) 1301 Gervais Street, Suite 200 Columbia, SC 29202 Phone: 1-800-868-9095 (toll free) or 1-803-734-9900 (local) <a href="http://www.aging.sc.gov">www.aging.sc.gov</a>
Quality Improvement Organization	The Carolinas Center for Medical Excellence 246 Stoneridge Drive, Suite 200 Columbia, SC 29210 Phone: 1-800-922-3089 (toll free; in-state calls only) or 1-803-251-2215 (local) TTY: 1-800-735-8583 <a href="http://www2.thecarolinascenter.org/ccme/">http://www2.thecarolinascenter.org/ccme/</a>
State Medicaid Office	South Carolina Department of Health & Human Services P.O. Box 8206 Columbia, SC 29202 Phone: 1-888-549-0820 (toll free) or 1-803-898-2500 (local)
State Pharmacy Assistance Program	South Carolina Gap Assistance Pharmacy Program for Seniors P.O. Box 8206 Columbia, SC 29202 Phone: 1-888-549-0820 (toll free) or 1-803-898-2500 (local) <a href="http://www.scdhhs.gov/PartDSummary.asp">http://www.scdhhs.gov/PartDSummary.asp</a>

<b>State</b>	<b>South Dakota</b>
SHIP Name and Contact Information	Senior Health Information and Insurance Education 700 Governors Drive Pierre, SD 57501 Phone: 1-800-536-8197 (toll free) or 1-605-333-3314 (local) TTY: 711(In-State only) <a href="http://www.shiine.net">www.shiine.net</a>
Quality Improvement Organization	South Dakota Foundation for Medical Care, Inc. 2600 West 49 <sup>th</sup> Street, Suite 300 Sioux Falls, SD 57105 Phone: 1-800-MEDICARE (toll free) or 1-605-336-3505 (local) <a href="http://www.sdfmc.org/">http://www.sdfmc.org/</a>
State Medicaid Office	Department of Social Services of South Dakota 700 Governors Drive Pierre, SD 57501 Phone: 1-800-452-7691 (toll free; in-state calls only) or 1-605-773-3495 (local) or 1-800-305-9673 (Spanish)

<b>State</b>	<b>Tennessee</b>
SHIP Name and Contact Information	TN SHIP 500 Deaderick St. Nashville, TN 37243-0860 Phone: 1-877-801-0044 (toll free) or 1-615-741-2056 (local) TTY: 1-615-532-3893 <a href="http://www.state.tn.us/comaging/ship.html">http://www.state.tn.us/comaging/ship.html</a>
Quality Improvement Organization	Q Source 3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115 Phone: 1-800-528-2655 (toll free Memphis) or 1-866-514-8595 (toll free Nashville) <a href="http://www.qsource.org/">http://www.qsource.org/</a>
State Medicaid Office	Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 Phone: 1-866-311-4287 (toll free)

<b>State</b>	<b>Texas</b>
SHIP Name and Contact Information	Health Information Counseling and Advocacy Program 701 West 51 <sup>st</sup> Street Austin, TX 78751 Phone: 1-800-252-9240 (toll free) TTY: 1-800-735-2989 <a href="http://www.dads.state.tx.us/">http://www.dads.state.tx.us/</a>
Quality Improvement Organization	Texas Medical Foundation BridgePoint I, Suite 300 5918 West Courtyard Drive Austin, TX 78730-5036 Phone: 1-800-725-9216 (toll free) or 1-512-329-6610 (local) <a href="http://www.tmf.org/">http://www.tmf.org/</a>
State Medicaid Office	Health and Human Services Commission of Texas 4900 N. Lamar Blvd Austin, TX 78751 Phone: 1-877-541-7905 (toll free; in-state calls only) or 1-512-424-6500 (local) TTY: 1-512-424-6597
State Pharmacy Assistance Program	Kidney Health Care Program Texas Department of State Health Services 1100 W. 49 <sup>th</sup> Street; Mail Code 1938 Austin, TX 78756 Phone: 1-888-963-7111 (toll free) or 1-512-458-7111 (local) TTY: 1-800-735-2989

<b>State</b>	<b>Utah</b>
SHIP Name and Contact Information	Senior Health Insurance Program 120 North 200 West Salt Lake City, UT 84103 Phone: 1-877-424-4640 (toll free) or 1-801-538-3910 (local) <a href="http://www.hsdaas.utah.gov/insurance_programs.htm">http://www.hsdaas.utah.gov/insurance_programs.htm</a>
Quality Improvement Organization	HealthInsight 348 East 4500 South, Suite 300 Salt Lake City, UT 84107 Phone: 1-800-274-2290 (toll free) or 1-801-892-0155 (local) <a href="http://www.healthinsight.org/">http://www.healthinsight.org/</a>
State Medicaid Office	Utah Department of Health Cannon Health Building 288 North 1460 West Salt Lake City, UT 84114 Phone: 1-800-662-9651 (toll free) or 1-801-538-6155 (local) or 1-800-662-9651 (Spanish)

<b>State</b>	<b>Vermont</b>
SHIP Name and Contact Information	State Health Insurance Assistance Program 481 Summer Street, Suite 101 St. Johnsbury, VT 05819 Phone: 1-800-642-5119 (toll free; in-state calls only) or 1-802-748-5182 (local) <a href="http://www.medicarehelpvt.net">www.medicarehelpvt.net</a>
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 Phone: 1-800-772-0151 (toll free) or 1-603-749-1641 (local) <a href="http://www.nhcqf.org/">http://www.nhcqf.org/</a>
State Medicaid Office	The Office of Vermont Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495 Phone: 1-800-250-8427 (toll free; in-state calls only) or 1-802-879-5900 (local)
State Pharmacy Assistance Program	Vermont V-Pharm 312 Hurricane Lane, Suite 201 Williston, VT 05495 Phone: 1-800-250-8427 (toll free) TTY: 1-888-834-7898 <a href="http://www.greenmountaincare.org">http://www.greenmountaincare.org</a>

<b>State</b>	<b>Virginia</b>
SHIP Name and Contact Information	Virginia Insurance Counseling and Assistance Program 1600 Forest Avenue, Suite 100 Richmond, VA 23229-5009 Phone: 1-800-552-3402 (toll free) or 1-804-662-9333 (local) or 1-804-662-9334 (local) TTY: 1-800-552-3402 <a href="http://www.vda.virginia.gov">www.vda.virginia.gov</a>
Quality Improvement Organization	Virginia Health Quality Center 9830 Maryland Drive, Suite J Richmond, VA 23233 Phone: 1-866-263-8402 (toll free) or 1-804-289-5320 (local) <a href="http://www.vhqc.org/">http://www.vhqc.org/</a>
State Medicaid Office	Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, VA 23219 Phone: 1-804-786-7933 (local) TTY: 1-800-343-0634 <a href="http://www.dmas.virginia.gov/">http://www.dmas.virginia.gov/</a>

<b>State</b>	<b>Washington</b>
SHIP Name and Contact Information	Statewide Health Insurance Benefits Advisors Helpline P.O. Box 40256 Olympia, WA 98504-0256 Phone: 1-800-562-6900 (toll free) or TTY: 1-360-586-0241 <a href="http://www.insurance.wa.gov/shiba/index.shtml">http://www.insurance.wa.gov/shiba/index.shtml</a>
Quality Improvement Organization	QualisHealth PO Box 33400 Seattle, WA 98133-0400 Phone: 1-800-445-6941 (toll free) or 1-206-364-9700 (local) TTY: 711 (In-State only) <a href="http://www.qualishealthmedicare.org/">http://www.qualishealthmedicare.org/</a>
State Medicaid Office	Department of Social and Health Services of Washington Aging and Disability Services Administration 640 Woodland Square Loop Lacey, WA 98503 Phone: 1-800-422-3263 (toll free; in-state calls only) or 1-360-725-2460 (local) TTY: 1-877-905-0454
State Pharmacy Assistance Program	Washington State Health Insurance Pharmacy Assistance Program PO Box 1090 Great Bend, KS 67530 Phone: 1-800-877-5187 (toll free)

<b>State</b>	<b>West Virginia</b>
SHIP Name and Contact Information	West Virginia State Health Insurance Assistance Program 1900 Kanawha Blvd. East Charleston, WV 25305-0160 Phone: 1-877-987-4463 (toll free) or 1-304-558-3317 (local) <a href="http://www.wvship.org">www.wvship.org</a>
Quality Improvement Organization	WVMI Quality Insights 3001 Chesterfield Avenue Charleston, WV 25304 Phone: 1-800-642-8686 (toll free) or 1-304-346-9864 (local) <a href="http://www.qiww.org/wv/">http://www.qiww.org/wv/</a>
State Medicaid Office	West Virginia Department of Health & Human Resources 350 Capitol Street Room 251 Charleston, WV 25301-3709 Phone: 1-304-558-1700 (local) or 1-304-558-4398 (local) <a href="http://www.wvdhhr.org/">http://www.wvdhhr.org/</a>

<b>State</b>	<b>Wisconsin</b>
SHIP Name and Contact Information	Wisconsin SHIP 1 West Wilson Street Madison, WI 53707 Phone: 1-800-242-1060 (toll free) or 1-866-456-8211 (toll free) or 1-608-267-3201 (local) TTY: 1-866-796-9725 <a href="http://dhs.wisconsin.gov/aging/SHIP.htm">http://dhs.wisconsin.gov/aging/SHIP.htm</a>
Quality Improvement Organization	MetaStar Inc. 2909 Landmark Place Madison, WI 53713 Phone: 1-800-362-2320 (toll free) or 1-608-274-1940 (local) <a href="http://www.metastar.com/web/">http://www.metastar.com/web/</a>
State Medicaid Office	Wisconsin Department of Health and Family Services 6406 Bridge Road Madison, WI 53784 Phone: 1-800-362-3002 (toll free) or 1-608-266-1865 (local) TTY: 1-608-267-7371
State Pharmacy Assistance Program	SeniorCare PO Box 6710 Madison, WI 53716 Phone: 1-800-657-2038 (toll free) or 1-608-221-4746 (local) TTY: 1-608-250-3168 <a href="http://dhs.wisconsin.gov/medicaid/index.htm">http://dhs.wisconsin.gov/medicaid/index.htm</a>

<b>State</b>	<b>Wyoming</b>
SHIP Name and Contact Information	Wyoming State Health Insurance Information Program 106 West Adams Ave Riverton, WY 82501 Phone: 1-800-856-4398 (toll free) or 1-307-856-6880 <a href="http://www.wyomingseniors.com">www.wyomingseniors.com</a>
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation PO Box 2242 Glenrock, WY 82637 Phone: 1-877-810-6248 (toll free) or <a href="http://www.mpqhf.org/">http://www.mpqhf.org/</a>
State Medicaid Office	Wyoming EqualityCare Qwest Building 6101 Yellowstone Rd, Suite 210 Cheyenne, WY 82002 Phone: 1-307-777-7531 (local) TTY: 1-307-777-5648