Explain this Plan.

This is not an all-inclusive list of questions. It is what is most commonly asked.

Who can I call at Humana?

Please contact the Humana Group Medicare customer service team at **866-396-8810**. Humana has many different departments with their own customer care numbers. If you utilize any other Humana number, the representative may not be able to help you. The representatives at **866-396-8810** are specifically trained to address any questions regarding The Conference's custom plan.

What type of plan does The Conference have with Humana?

The Conference has a custom group Medicare Advantage PPO plan. This plan provides coverage for all Medicare-covered Part A and Part B services and it includes the supplemental medical benefits in a single plan offering. This PPO plan has the same benefits and cost shares for in and out of network providers. So, whether you use an in-network provider or an out of network provider, the member's cost share is the same.

What is Part A and Part B? I have also heard of Part C and D? What do they cover?

Parts A and B are called Original Medicare. Part A and Part B is what you sign up for with Social Security. Most people do not have to pay for Part A but everyone is required to pay for Medicare Part B.

Medicare Part A is hospital insurance. It helps pay for inpatient care in a hospital or skilled nursing facility. It also pays for some home healthcare and hospice care. Medicare Part B is medical insurance. Part B helps cover medically necessary doctors' services, outpatient care and other medical services and supplies. Part B also covers some preventive services.

Medicare Part C (Medicare Advantage) is available through private insurance companies. Medicare Part C covers everything parts A and B cover, including hospital and medical services. You still have Medicare if you elect Medicare part C coverage. Also, you do not need to sign up for a Medicare Supplement plan. Lastly, Medicare Advantage plans give you access to programs (like wellness, clinical and educational) at no additional cost to you. Medicare Advantage plans give you the ease of one card and one place to call with questions. With Humana's plan, members have access to programs such as SilverSneakers which is a free gym membership and Go365, which is Humana's wellness program.

Part D is prescription drug coverage. Your prescription drug coverage is through ExpressScripts, not Humana.

Have I lost Medicare?

No, you have not. Only people who are Medicare members are eligible for a Medicare Advantage Plan. In order to have this plan, you must have Part A and Part B. Your enrollment on this plan is shared with the Federal government. If you stop paying your Medicare premium(s) to Social Security, Medicare will inform Humana that you are no longer eligible for this plan.

Is this a different kind of supplement plan?
No, it is not a supplement plan. A Medicare Advantage plan and a Medicare supplement are two very different types of plans.

A Medicare supplement plan pays after Medicare. As an example, if you went to the doctor, the doctor's office would first send the claim to Medicare. Then they would send the claim to the Medicare supplement plan to pay (according to your benefits) what Medicare states is the individual responsibility.

A Medicare Advantage plan pays instead of Medicare. You only need to use your Humana ID card when receiving services. Please keep your Medicare card (red, white, and blue) in a safe place. Do not present it to your providers when receiving services. As a Medicare Advantage carrier Humana is responsible for paying on behalf of Medicare for all Medicare covered services.

Should I buy another supplement plan or another Medicare Advantage plan?
No, you should not. It is illegal for anyone to knowingly sell a Medicare Advantage member a supplement plan as the two plans do not coordinate. Medicare only permits an individual to have one Medicare Advantage Plan.

If you independently sign up for another Medicare Advantage plan after being enrolled, the Federal government will remove you from your Medicare Advantage plans through The Conference.

My neighbor has Humana, are our plans the same?
No, The Conference's plan is a *custom* group Medicare Advantage plan; it is unique and only available to The Conference's members. There are many provisions in The Conference's plan that are not available to other Humana Medicare members.

What is the value of a Medicare Advantage plan compared to Original Medicare and a commercial secondary plan?

Humana Medicare Advantage plans are designed to encourage members to improve wellness and stay healthy. Humana developed programs and services that enable customers and their doctors to focus on prevention, such as breast cancer prevention, flu and pneumonia vaccination, and effective case and disease management programs targeted to the senior population. Additionally, Humana offers wellness programs aimed at helping seniors achieve and maintain a healthy and active lifestyle.

How does this plan work?

What does this plan cover?
All Medicare-covered services are covered by this plan. Humana's Medicare Advantage plan follows all Medicare guidelines to determine medical necessity. In addition to Medicare covered services, Medicare Advantage plans are also allowed to add on services. As examples, Humana offers Well Dine and Go365. Well Dine provides up to 28 flash frozen meals delivered to your home upon discharge from the hospital or a skilled nursing facility. Go365 is a wellness program where a person can earn rewards through different wellness activities, as an example getting an annual physical.

Does the plan require me to have a referral to see a specialist?
No, the plan does not require referrals. You are welcome to see any provider who accepts Medicare and is willing to bill Humana. Please be aware that there are some specialties where it is more common for the physician's office to require you to have a referral to be seen. Some examples are endocrinologists, neurologists, and cardiologists. If a provider requests a referral that is at their office's discretion; this Humana plan does not require referrals.

If my service requires an authorization, what criteria is used?
As a Medicare Advantage plan, Humana is required to use Medicare's criteria to determine medical necessity; if your circumstances meet Medicare's definition of medical necessity it will be approved.

Medicare didn't require authorizations, why does Humana?
Medicare does retrospective reviews for medical necessity. Most Medicare Advantage reviews carriers occur on the front end. The criteria that must be met are the same as a Medicare Advantage carrier (i.e. Humana) is required to use Medicare's guidelines of necessity.

A prior authorization is submitted prior to a service taking place due to the need for a clinical or medical review. This is usually submitted by your provider on your behalf. If you have concerns with the length of time it is taking for your provider to obtain an authorization you can call Humana for assistance.

Processing Timeframes:

- For ***urgent/expedited*** requests, the time allotted is as quickly as possible not to exceed ***72 hours***. (These hours are actual hours and not business hours.)
- For ***non-urgent/non-expedited*** requests, the time allotted is as quickly as possible not to exceed ***14 days*** from the date of request.

Should you have an emergency medical situation and need to be admitted, the hospital will admit you prior to requesting an authorization. Authorizations in advance are for planned procedures scheduled for the future.

What recourse do I have if I or my provider disagrees with Humana on a claim or an authorization?
You and/or your provider may appeal. Your appeal will be reviewed to ensure that coverage was determined based on Medicare's guidelines and/or that the claim processed according to your benefits.

If Humana does not reverse its initial decision, you will be given additional appeal rights which include an independent third party. The independent third party is called a Quality Improvement Organization (QIO). QIO's are directly contracted with Medicare and will review to ensure that Humana has followed Medicare's guidelines. Should the QIO disagree with Humana's decision, Humana will follow the direction given by the QIO.

Do I have to see a medical provider that is in-network with Humana?
No, you do not. You may see any provider that accepts Medicare and is willing to bill Humana. You may see an out of network provider as long as they accept Medicare and are willing to bill Humana. You simply pay your cost share and Humana takes care of the rest.

Are my benefits different if my medical provider is not in-network with Humana?
No, they are not. Your benefits are the same in or outside of Humana's network.

My provider won't see me because they say they are not in Humana's network
Please call Humana. Humana will call your provider's office to explain the type of plan The Conference has for its members. The Conference's plan is unique, providers are not required to be in Humana's network and your benefits don't change as long as you see a Medicare provider that bills Humana.

What are providers paid?
In-network with Humana:
Providers will be reimbursed at their contracted rate and will need to follow their standard processes for Humana. All services are covered according to Medicare's guidelines.

Out-of-network:
The total payment will equal 100 percent of what Medicare would pay the provider. Humana will process claims for out of network providers using Medicare's fee schedule. The Medicare fee schedule is what Medicare states is the appropriate reimbursement for a service. Once your portion (please refer to you plan documents for the copays for each type of service) is taken into account, the total reimbursement amount for all Medicare-covered services will be 100 percent.
All services are covered according to Medicare's guidelines.

How do medical providers submit claims?
A provider will only be required to submit a claim to Humana. There is no need to bill Original Medicare. The provider can submit claims electronically or by paper.

CMS-1500: Used for physician and diagnostic services.

UB-92 & UB-04: Used to submit hospital and/or ancillary related services for reimbursement.

Where would the provider submit a paper claim?
The claims mailing address is located on the back of your Humana ID card.

How quickly are claims issues corrected?
Humana Customer Care is available Mon – Fri, 8 a.m. to 9 p.m. EST to answer questions about claims. If there is an issue and the claim needs to be reworked, Humana's Claims Rework Unit would review corrected claims and/or processing errors. The reprocessing of the claim would all be made within 30 days of submission.

Humana called and asked if I was willing to work with their clinical staff
If you are eligible for a clinical program, a member from Humana's staff will reach out to you and ask if you are willing to work with a nurse. While we encourage people to engage if contacted, you are not required to participate.

I'm curious about Humana's network. How do I find an in-network provider?

- www.humana.com/findadoctor
- **Find a doctor**: Click the tab to select a doctor or a pharmacy

Medical:

- **Location -**Enter a Zip code and the distance radius you want to search
- **Select a lookup method –** once you have a member ID you can either search by member ID or sign into MyHumana, both options will automatically pull your network. Prior to having your member ID, under "Coverage Type" please select **"Medicare or Medicare-Medicaid"**
- **Coverage year -** select 2023
- **Network-** Medicare PPO/Employer PPO Plus
- You may elect a search category to narrow down the options that will pull when you type in the name of the provider you are searching for under "Name, Specialty, Condition"
- Once you have made your selections, click on "Search" on the bottom left hand side of the page

Please contact the Humana Group Medicare customer service team at **866-396-8810** if you would like assistance searching for a provider or have any other question related to the Humana Medicare Advantage plan being offered to you.